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104TH CONGRESS
1ST SESSION

H. R. 2486

To amend title XVIII of the Social Security Act to preserve and reform the medicare program.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 17, 1995

Mr. PETERSON of Minnesota introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, the Judiciary, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to preserve and reform the medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **TITLE XV—MEDICARE**

4 **SEC. 15000. SHORT TITLE; REFERENCES IN TITLE; TABLE**
5 **OF CONTENTS.**

6 (a) SHORT TITLE OF TITLE.—This title may be cited
7 as the “Medicare Preservation Act of 1995”.

8 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-
9 cept as otherwise specifically provided, whenever in this

1 title an amendment is expressed in terms of an amend-
 2 ment to or repeal of a section or other provision, the ref-
 3 erence shall be considered to be made to that section or
 4 other provision of the Social Security Act.

5 (c) REFERENCES TO OBRA.—In this title, the terms
 6 “OBRA-1986”, “OBRA-1987”, “OBRA-1989”,
 7 “OBRA-1990”, and “OBRA-1993” refer to the Omnibus
 8 Budget Reconciliation Act of 1986 (Public Law 99-509),
 9 the Omnibus Budget Reconciliation Act of 1987 (Public
 10 Law 100-203), the Omnibus Budget Reconciliation Act
 11 of 1989 (Public Law 101-239), the Omnibus Budget Rec-
 12 onciliation Act of 1990 (Public Law 101-508), and the
 13 Omnibus Budget Reconciliation Act of 1993 (Public Law
 14 103-66), respectively.

15 (c) TABLE OF CONTENTS.—The table of contents of
 16 this title is as follows:

TITLE VIII—MEDICARE

Sec. 15000. Short title; references in title; table of contents.

Subtitle A—Medicare Choice Program

PART 1—INCREASING CHOICE UNDER THE MEDICARE PROGRAM

Sec. 15001. Increasing choice under Medicare.

Sec. 15002. Medicare Choice Program.

“PART C—PROVISIONS RELATING TO MEDICARE CHOICE

“Sec. 1851. Requirements for Medicare Choice organizations.

“Sec. 1852. Requirements relating to benefits, provision of services, enroll-
 ment, and premiums.

“Sec. 1853. Patient protection standards.

“Sec. 1854. Provider-sponsored organizations.

“Sec. 1855. Payments to Medicare choice organizations.

“Sec. 1856. Establishment of standards for Medicare choice organizations
 and products.

3

"Sec. 1857. Medicare choice certification.

"Sec. 1858. Contracts with Medicare Choice organizations.

"Sec. 1859. Demonstration project for high deductible/medisave products.

Sec. 15003. Reports.

Sec. 15004. Transitional rules for current Medicare HMO program.

PART 2—SPECIAL RULES FOR MEDICARE CHOICE MEDICAL SAVINGS
ACCOUNTS

Sec. 15011. Medicare Choice MSA's.

Sec. 15012. Certain rebates excluded from gross income.

PART 3—SPECIAL ANTITRUST RULE FOR PROVIDER SERVICE NETWORKS

Sec. 15021. Application of antitrust rule of reason to provider service networks.

PART 4—COMMISSIONS

Sec. 15031. Medicare payment review commission.

Sec. 15032. Commission on the Effect of the Baby Boom Generation on the Medicare Program.

PART 5—PREEMPTION OF STATE ANTI-MANAGED CARE LAWS

Sec. 15041. Preemption of State law restrictions on managed care arrangements.

Sec. 15042. Preemption of State laws restricting utilization review programs.

Subtitle B—Provisions Relating to Regulatory Relief

PART 1—PROVISIONS RELATING TO PHYSICIAN FINANCIAL RELATIONSHIPS

Sec. 15101. Repeal of prohibitions based on compensation arrangements.

Sec. 15102. Revision of designated health services subject to prohibition.

Sec. 15103. Delay in implementation until promulgation of regulations.

Sec. 15104. Exceptions to prohibition.

Sec. 15105. Repeal of reporting requirements.

Sec. 15106. Preemption of State law.

Sec. 15107. Effective date.

PART 2—ANTITRUST REFORM

Sec. 15111. Publication of antitrust guidelines on activities of health plans.

Sec. 15112. Issuance of health care certificates of public advantage.

Sec. 15113. Study of impact on competition.

Sec. 15114. Antitrust exemption.

Sec. 15115. Requirements.

Sec. 15116. Definitions.

PART 3—MALPRACTICE REFORM

SUBPART A—UNIFORM STANDARDS FOR MALPRACTICE CLAIMS

Sec. 15121. Applicability.

Sec. 15122. Requirement for initial resolution of action through alternative dispute resolution.

Sec. 15123. Optional application of practice guidelines.

Sec. 15124. Treatment of noneconomic and punitive damages.

Sec. 15125. Periodic payments for future losses.

- Sec. 15126. Treatment of attorney's fees and other costs.
- Sec. 15127. Uniform statute of limitations.
- Sec. 15128. Special provision for certain obstetric services.
- Sec. 15129. Jurisdiction of Federal courts.
- Sec. 15130. Preemption.

SUBPART B—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION
(ADR) SYSTEMS

- Sec. 15131. Basic requirements.
- Sec. 15132. Certification of State systems; applicability of alternative Federal system.
- Sec. 15133. Reports on implementation and effectiveness of alternative dispute resolution systems.

SUBPART C—DEFINITIONS

- Sec. 15141. Definitions.

PART 4—PAYMENT AREAS FOR PHYSICIANS' SERVICES UNDER MEDICARE

- Sec. 15151. Modification of payment areas used to determine payments for physicians' services under medicare.

Subtitle C—Medicare Payments to Health Care Providers

PART 1—PROVISIONS AFFECTING ALL PROVIDERS

- Sec. 15201. One-year freeze in payments to providers.

PART 2—PROVISIONS AFFECTING DOCTORS

- Sec. 15211. Updating fees for physicians' services.
- Sec. 15212. Use of real GDP to adjust for volume and intensity.

PART 3—PROVISIONS AFFECTING HOSPITALS

- Sec. 15221. Reduction in update for inpatient hospital services.
- Sec. 15222. Elimination of formula-driven overpayments for certain outpatient hospital services.
- Sec. 15223. Establishment of prospective payment system for outpatient services.
- Sec. 15224. Reduction in medicare payments to hospitals for inpatient capital-related costs.
- Sec. 15225. Moratorium on PPS exemption for long-term care hospitals.
- Sec. 15226. Elimination of certain additional payments for outlier cases.

PART 4—PROVISIONS AFFECTING OTHER PROVIDERS

- Sec. 15231. Revision of payment methodology for home health services.
- Sec. 15232. Limitation of home health coverage under part A.
- Sec. 15233. Reduction in fee schedule for durable medical equipment.
- Sec. 15234. Nursing home billing.
- Sec. 15235. Freeze in payments for clinical diagnostic laboratory tests.

PART 5—GRADUATE MEDICAL EDUCATION AND TEACHING HOSPITALS

- Sec. 15241. Teaching Hospital and Graduate Medical Education Trust Fund.

“TITLE XXI—TEACHING HOSPITAL AND GRADUATE MEDICAL
EDUCATION TRUST FUND

“PART A—ESTABLISHMENT OF FUND

“Sec. 2101. Establishment of fund.

“PART B—PAYMENTS TO TEACHING HOSPITALS

“Sec. 2111. Formula payments to teaching hospitals.

Sec. 15242. Reduction in payment adjustments for indirect medical education.

Subtitle D—Provisions Relating to Medicare Beneficiaries

Sec. 15301. Extending medicare part B premium.

Sec. 15302. Relating medicare part B premium to income for certain high income individuals.

Sec. 15303. Expanded coverage of preventive benefits.

Subtitle E—Medicare Fraud Reduction

Sec. 15401. Increasing beneficiary awareness of fraud and abuse.

Sec. 15402. Beneficiary incentives to report fraud and abuse.

Sec. 15403. Elimination of home health overpayments.

Sec. 15404. Skilled nursing facilities.

Sec. 15405. Direct spending for anti-fraud activities under medicare.

Sec. 15406. Fraud reduction demonstration project.

Sec. 15407. Report on competitive pricing.

Subtitle F—Improving Access to Health Care

PART 1—IMPROVING ACCESS TO HEALTH CARE IN RURAL AREAS

Sec. 15501. Community rural health network grants.

Sec. 15502. Provider incentives.

Sec. 15503. Modifications to the National Health Service Corps.

Sec. 15504. Creation of hospital-affiliated primary care centers.

Sec. 15505. Establishment of rural emergency access care hospitals.

Sec. 15506. Medical education.

Sec. 15507. Telemedicine payment methodology.

Sec. 15508. Demonstration project to increase choice in rural areas.

PART 2—MEDICARE SUBVENTION

Sec. 15511. Medicare program payments for health care services provided in the military health services system.

Subtitle G—Other Provisions

Sec. 15601. Extension and expansion of existing secondary payer requirements.

Sec. 15602. Clarification of medicare coverage of items and services associated with certain medical devices approved for investigational use.

Sec. 15603. Additional exclusion from coverage.

Subtitle H—Monitoring Achievement of Medicare Reform Goals

Sec. 15701. Establishment of budgetary and program goals.

Sec. 15702. Medicare Reform Commission.

Subtitle I—Lock-Box Provisions for Medicare Part B Savings From Growth Reductions

Sec. 15801. Establishment of Medicare Growth Reduction Trust Fund for part B savings.

1 Subtitle A—Medicare Choice
2 Program

3 PART 1—INCREASING CHOICE UNDER THE
4 MEDICARE PROGRAM

5 SEC. 15001. INCREASING CHOICE UNDER MEDICARE.

6 (a) IN GENERAL.—Title XVIII is amended by insert-
7 ing after section 1804 the following new section:

8 “PROVIDING FOR CHOICE OF COVERAGE

9 “SEC. 1805. (a) CHOICE OF COVERAGE.—

10 “(1) IN GENERAL.—Subject to the provisions of
11 this section, every individual who is entitled to bene-
12 fits under part A and enrolled under part B shall
13 elect to receive benefits under this title through one
14 of the following:

15 “(A) THROUGH FEE-FOR-SERVICE SYS-
16 TEM.—Through the provisions of parts A and
17 B.

18 “(B) THROUGH A MEDICARE CHOICE
19 PRODUCT.—Through a Medicare Choice prod-
20 uct (as defined in paragraph (2)), which may
21 be—

22 “(i) a product offered by a provider-
23 sponsored organization,

1 “(ii) a product offered by an organiza-
2 tion that is a union, Taft-Hartley plan, or
3 association, or

4 “(iii) a product providing for benefits
5 on a fee-for-service or other basis.

6 Such a product may be a high deductible/
7 medisave product (and a contribution into a
8 Medicare Choice medical savings account
9 (MSA)) under the demonstration project pro-
10 vided under section 1859.

11 “(2) MEDICARE CHOICE PRODUCT DEFINED.—

12 For purposes this section and part C, the term
13 ‘Medicare Choice product’ means health benefits cov-
14 erage offered under a policy, contract, or plan by a
15 Medicare Choice organization (as defined in section
16 1851(a)) pursuant to and in accordance with a con-
17 tract under section 1858.

18 “(3) TERMINOLOGY RELATING TO OPTIONS.—

19 For purposes of this section and part C—

20 “(A) NON-MEDICARE-CHOICE OPTION.—An
21 individual who has made the election described
22 in paragraph (1)(A) is considered to have elect-
23 ed the ‘Non-Medicare Choice option’.

24 “(B) MEDICARE CHOICE OPTION.—An in-
25 dividual who has made the election described in

1 paragraph (1)(B) to obtain coverage through a
2 Medicare Choice product is considered to have
3 elected the ‘Medicare Choice option’ for that
4 product.

5 “(b) SPECIAL RULES.—

6 “(1) RESIDENCE REQUIREMENT.—Except as
7 the Secretary may otherwise provide, an individual is
8 eligible to elect a Medicare Choice product offered by
9 a Medicare Choice organization only if the organiza-
10 tion in relation to the product serves the geographic
11 area in which the individual resides.

12 “(2) AFFILIATION REQUIREMENTS FOR CER-
13 TAIN PRODUCTS.—

14 “(A) IN GENERAL.—Subject to subpara-
15 graph (B), an individual is eligible to elect a
16 Medicare Choice product offered by a limited
17 enrollment Medicare Choice organization (as de-
18 fined in section 1852(c)(4)(D)) only if—

19 “(i) the individual is eligible under
20 section 1852(c)(4) to make such election,
21 and

22 “(ii) in the case of a Medicare Choice
23 organization that is a union sponsor or
24 Taft-Hartley sponsor (as defined in section
25 1852(c)(4)), the individual elected under

1 this section a Medicare Choice product of-
2 ferred by the sponsor during the first en-
3 rollment period in which the individual was
4 eligible to make such election with respect
5 to such sponsor.

6 “(B) No REELECTION AFTER
7 DISENROLLMENT FOR CERTAIN PRODUCTS.—

8 An individual is not eligible to elect a Medicare
9 Choice product offered by a Medicare Choice
10 organization that is a union sponsor or Taft-
11 Hartley sponsor if the individual previously had
12 elected a Medicare Choice product offered by
13 the organization and had subsequently discon-
14 tinued to elect such a product offered by the or-
15 ganization.

16 “(c) PROCESS FOR EXERCISING CHOICE.—

17 “(1) IN GENERAL.—The Secretary shall estab-
18 lish a process through which elections described in
19 subsection (a) are made and changed, including the
20 form and manner in which such elections are made
21 and changed. Such elections shall be made or
22 changed only during coverage election periods speci-
23 fied under subsection (e) and shall become effective
24 as provided in subsection (f).

1 “(2) EXPEDITED IMPLEMENTATION.—The Sec-
2 retary shall establish the process of electing coverage
3 under this section during the transition period (as
4 defined in subsection (e)(1)(B)) in such an expedited
5 manner as will permit such an election for Medicare
6 Choice products in an area as soon as such products
7 become available in that area.

8 “(3) COORDINATION THROUGH MEDICARE
9 CHOICE ORGANIZATIONS.—

10 “(A) ENROLLMENT.—Such process shall
11 permit an individual who wishes to elect a Med-
12 icare Choice product offered by a Medicare
13 Choice organization to make such election
14 through the filing of an appropriate election
15 form with the organization.

16 “(B) DISENROLLMENT.—Such process
17 shall permit an individual, who has elected a
18 Medicare Choice product offered by a Medicare
19 Choice organization and who wishes to termi-
20 nate such election, to terminate such election
21 through the filing of an appropriate election
22 form with the organization.

23 “(4) DEFAULT.—

24 “(A) INITIAL ELECTION.—

“(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the Non-Medicare Choice option.

“(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary shall establish procedures under which individuals who are enrolled with a Medicare Choice organization at the time of the initial election period and who fail to elect to receive coverage other than through the organization are deemed to have elected an appropriate Medicare Choice product offered by the organization.

“(B) CONTINUING PERIODS.—An individual who has made (or deemed to have made) an election under this section is considered to have continued to make such election until such time as—

“(i) the individual changes the election under this section, or

“(ii) a Medicare Choice product is discontinued, if the individual had elected

1 such product at the time of the discontinu-
2 ation.

3 “(5) AGREEMENTS WITH COMMISSIONER OF SO-
4 CIAL SECURITY TO PROMOTE EFFICIENT ADMINIS-
5 TRATION.—In order to promote the efficient admin-
6 istration of this section and the Medicare Choice
7 program under part C, the Secretary may enter into
8 an agreement with the Commissioner of Social Secu-
9 rity under which the Commissioner performs admin-
10 istrative responsibilities relating to enrollment and
11 disenrollment in Medicare Choice products under
12 this section.

13 “(d) PROVISION OF BENEFICIARY INFORMATION TO
14 PROMOTE INFORMED CHOICE.—

15 “(1) IN GENERAL.—The Secretary shall provide
16 for activities under this subsection to disseminate
17 broadly information to medicare beneficiaries (and
18 prospective medicare beneficiaries) on the coverage
19 options provided under this section in order to pro-
20 mote an active, informed selection among such op-
21 tions. Such information shall be made available on
22 such a timely basis (such as 6 months before the
23 date an individual would first attain eligibility for
24 medicare on the basis of age) as to permit individ-

uals to elect the Medicare Choice option during the initial election period described in subsection (e)(1).

“(2) USE OF NONFEDERAL ENTITIES.—The Secretary shall, to the maximum extent feasible, enter into contracts with appropriate non-Federal entities to carry out activities under this subsection.

“(3) SPECIFIC ACTIVITIES.—In carrying out this subsection, the Secretary shall provide for at least the following activities in all areas in which Medicare Choice products are offered:

“(A) INFORMATION BOOKLET.—

“(i) IN GENERAL.—The Secretary shall publish an information booklet and disseminate the booklet to all individuals eligible to elect the Medicare Choice option under this section during coverage election periods.

“(ii) INFORMATION INCLUDED.—The booklet shall include information presented in plain English and in a standardized format regarding—

“(I) the benefits (including cost-sharing) and premiums for the various Medicare Choice products in the areas involved;

1 “(II) the quality of such prod-
2 ucts, including consumer satisfaction
3 information; and

4 “(III) rights and responsibilities
5 of medicare beneficiaries under such
6 products.

7 “(iii) PERIODIC UPDATING.—The
8 booklet shall be updated on a regular basis
9 (not less often than once every 12 months)
10 to reflect changes in the availability of
11 Medicare Choice products and the benefits
12 and premiums for such products.

13 “(B) TOLL-FREE NUMBER.—The Secretary
14 shall maintain a toll-free number for inquiries
15 regarding Medicare Choice options and the op-
16 eration of part C.

17 “(C) GENERAL INFORMATION IN MEDI-
18 CARE HANDBOOK.—The Secretary shall include
19 information about the Medicare Choice option
20 provided under this section in the annual notice
21 of medicare benefits under section 1804.

22 “(e) COVERAGE ELECTION PERIODS.—

23 “(1) INITIAL CHOICE UPON ELIGIBILITY TO
24 MAKE ELECTION.—

“(A) IN GENERAL.—In the case of an individual who first becomes entitled to benefits under part A and enrolled under part B after the beginning of the transition period (as defined in subparagraph (B)), the individual shall make the election under this section during a period (of a duration and beginning at a time specified by the Secretary) at the first time the individual both is entitled to benefits under part A and enrolled under part B. Such period shall be specified in a manner so that, in the case of an individual who elects a Medicare Choice product during the period, coverage under the product becomes effective as of the first date on which the individual may receive such coverage.

“(B) TRANSITION PERIOD DEFINED.—In this subsection, the term ‘transition period’ means, with respect to an individual in an area, the period beginning on the first day of the first month in which a Medicare Choice product is first made available to individuals in the area and ending with the month preceding the beginning of the first annual, coordinated election period under paragraph (3).

1 “(2) DURING TRANSITION PERIOD.—Subject to
2 paragraph (6)—

3 “(A) CONTINUOUS OPEN ENROLLMENT
4 INTO A MEDICARE CHOICE OPTION.—During
5 the transition period, an individual who is eligi-
6 ble to make an election under this section and
7 who has elected the non-Medicare Choice option
8 may change such election to a Medicare Choice
9 option at any time.

10 “(B) OPEN DISENROLLMENT BEFORE END
11 OF TRANSITION PERIOD.—During the transition
12 period, an individual who has elected a Medi-
13 care Choice option for a Medicare Choice prod-
14 uct may change such election to another Medi-
15 care Choice product or to the non-Medicare
16 Choice option.

17 “(3) ANNUAL, COORDINATED ELECTION PE-
18 RIOD.—

19 “(A) IN GENERAL.—Subject to paragraph
20 (5), each individual who is eligible to make an
21 election under this section may change such
22 election during annual, coordinated election pe-
23 riods.

24 “(B) ANNUAL, COORDINATED ELECTION
25 PERIOD.—For purposes of this section, the

term ‘annual, coordinated election period’ means, with respect to a calendar year (beginning with 1998), the month of October before such year.

“(C) MEDICARE CHOICE HEALTH FAIR DURING OCTOBER, 1996.—In the month of October, 1996, the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform individuals, who are eligible to elect Medicare Choice products, about such products and the election process provided under this section (including the annual, coordinated election periods that occur in subsequent years).

“(4) SPECIAL 90-DAY DISENROLLMENT OPTION.—

“(A) IN GENERAL.—In the case of the first time an individual elects a Medicare Choice option under this section, the individual may discontinue such election through the filing of an appropriate notice during the 90-day period beginning on the first day on which the individual’s coverage under the Medicare Choice product under such option becomes effective.

1 “(B) EFFECT OF DISCONTINUATION OF
2 ELECTION.—An individual who discontinues an
3 election under this paragraph shall be deemed
4 at the time of such discontinuation to have
5 elected the Non-Medicare Choice option.

6 “(5) SPECIAL ELECTION PERIODS.—An individ-
7 ual may discontinue an election of a Medicare
8 Choice product offered by a Medicare Choice organi-
9 zation other than during an annual, coordinated
10 election period and make a new election under this
11 section if—

12 “(A) the organization’s or product’s certifi-
13 cation under part C has been terminated or the
14 organization has terminated or otherwise dis-
15 continued providing the product;

16 “(B) in the case of an individual who has
17 elected a Medicare Choice product offered by a
18 Medicare Choice organization, the individual is
19 no longer eligible to elect the product because
20 of a change in the individual’s place of resi-
21 dence or other change in circumstances (speci-
22 fied by the Secretary, but not including termi-
23 nation of membership in a qualified association
24 in the case of a product offered by a qualified
25 association or termination of the individual’s

enrollment on the basis described in clause (i) or (ii) section 1852(c)(3)(B));

“(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

“(i) the organization offering the product substantially violated a material provision of the organization’s contract under part C in relation to the individual and the product; or

“(ii) the organization (or an agent or other entity acting on the organization’s behalf) materially misrepresented the product’s provisions in marketing the product to the individual; or

“(D) the individual meets such other conditions as the Secretary may provide.

“(f) EFFECTIVENESS OF ELECTIONS.—

“(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may

1 provide (consistent with section 1838) in order to
2 prevent retroactive coverage.

3 “(2) DURING TRANSITION; 90-DAY
4 DISENROLLMENT OPTION.—An election of coverage
5 made under subsection (e)(2) and an election to dis-
6 continue a Medicare Choice option under subsection
7 (e)(4) at any time shall take effect with the first cal-
8 endar month following the date on which the election
9 is made.

10 “(3) ANNUAL, COORDINATED ELECTION PERIOD
11 AND MEDISAVE ELECTION.—An election of coverage
12 made during an annual, coordinated election period
13 (as defined in subsection (e)(3)(B)) in a year shall
14 take effect as of the first day of the following year.

15 “(4) OTHER PERIODS.—An election of coverage
16 made during any other period under subsection
17 (e)(5) shall take effect in such manner as the Sec-
18 retary provides in a manner consistent (to the extent
19 practicable) with protecting continuity of health ben-
20 efit coverage.

21 “(g) EFFECT OF ELECTION OF MEDICARE CHOICE
22 OPTION.—Subject to the provisions of section 1855(f),
23 payments under a contract with a Medicare Choice organi-
24 zation under section 1858(a) with respect to an individual
25 electing a Medicare Choice product offered by the organi-

1 zation shall be instead of the amounts which (in the ab-
2 sence of the contract) would otherwise be payable under
3 parts A and B for items and services furnished to the indi-
4 vidual.

5 “(h) DEMONSTRATION PROJECTS.—The Secretary
6 shall conduct demonstration projects to test alternative
7 approaches to coordinated open enrollments in different
8 markets, including different annual enrollment periods
9 and models of rolling open enrollment periods. The Sec-
10 retary may waive previous provisions of this section in
11 order to carry out such projects.”

12 **SEC. 15002. MEDICARE CHOICE PROGRAM.**

13 (a) IN GENERAL.—Title XVIII is amended by redes-
14 ignating part C as part D and by inserting after part B
15 the following new part:

16 “PART C—PROVISIONS RELATING TO MEDICARE
17 CHOICE

18 “REQUIREMENTS FOR MEDICARE CHOICE ORGANIZATIONS

19 “SEC. 1851. (a) MEDICARE CHOICE ORGANIZATION
20 DEFINED.—In this part, subject to the succeeding provi-
21 sions of this section, the term ‘Medicare Choice organiza-
22 tion’ means a public or private entity that is certified
23 under section 1857 as meeting the requirements and
24 standards of this part for such an organization.

1 “(b) ORGANIZED AND LICENSED UNDER STATE
2 LAW.—

3 “(1) IN GENERAL.—A Medicare Choice organi-
4 zation shall be organized and licensed under State
5 law to offer health insurance or health benefits cov-
6 erage in each State in which it offers a Medicare
7 Choice product.

8 “(2) EXCEPTION FOR UNION AND TAFT-HART-
9 LEY SPONSORS.—Paragraph (1) shall not apply to a
10 Medicare Choice organization that is a union spon-
11 sor or Taft-Hartley sponsor (as defined in section
12 1852(c)(4)).

13 “(3) EXCEPTION FOR PROVIDER-SPONSORED
14 ORGANIZATIONS.—Paragraph (1) shall not apply to
15 a Medicare Choice organization that is a provider-
16 sponsored organization (as defined in section
17 1854(a)) except to the extent provided under section
18 1857(b).

19 “(4) EXCEPTION FOR QUALIFIED ASSOCIA-
20 TIONS.—Paragraph (1) shall not apply to a Medi-
21 care Choice organization that is a qualified associa-
22 tion (as defined in section 1852(c)(4)(B)).

23 “(c) PREPAID PAYMENT.—A Medicare Choice orga-
24 nization shall be compensated (except for deductibles, co-
25 insurance, and copayments) for the provision of health

1 care services to enrolled members by a payment which is
2 paid on a periodic basis without regard to the date the
3 health care services are provided and which is fixed with-
4 out regard to the frequency, extent, or kind of health care
5 service actually provided to a member.

6 “(d) ASSUMPTION OF FULL FINANCIAL RISK.—The
7 Medicare Choice organization shall assume full financial
8 risk on a prospective basis for the provision of the health
9 care services (other than hospice care) for which benefits
10 are required to be provided under section 1852(a)(1), ex-
11 cept that the organization—

12 “(1) may obtain insurance or make other ar-
13 rangements for the cost of providing to any enrolled
14 member such services the aggregate value of which
15 exceeds \$5,000 in any year,

16 “(2) may obtain insurance or make other ar-
17 rangements for the cost of such services provided to
18 its enrolled members other than through the organi-
19 zation because medical necessity required their pro-
20 vision before they could be secured through the orga-
21 nization,

22 “(3) may obtain insurance or make other ar-
23 rangements for not more than 90 percent of the
24 amount by which its costs for any of its fiscal years

1 exceed 115 percent of its income for such fiscal year,
2 and

3 “(4) may make arrangements with physicians
4 or other health professionals, health care institu-
5 tions, or any combination of such individuals or in-
6 stitutions to assume all or part of the financial risk
7 on a prospective basis for the provision of basic
8 health services by the physicians or other health pro-
9 fessionals or through the institutions.

10 In the case of a Medicare Choice organization that is a
11 union sponsor or Taft-Hartley sponsor (as defined in sec-
12 tion 1852(c)(4)) or a qualified association (as defined in
13 section 1852(c)(4)(B)), this subsection shall not apply
14 with respect to Medicare Choice products offered by such
15 organization and issued by an organization to which sub-
16 section (b)(1) applies or by a provider-sponsored organiza-
17 tion (as defined in section 1854(a)).

18 “(e) PROVISION AGAINST RISK OF INSOLVENCY.—

19 “(1) IN GENERAL.—Each Medicare Choice or-
20 ganization shall meet standards under section 1856
21 relating to the financial solvency and capital ade-
22 quacy of the organization. Such standards shall take
23 into account the nature and type of Medicare Choice
24 products offered by the organization.

1 “(2) TREATMENT OF TAFT-HARTLEY SPON-
2 SORS.—An entity that is a Taft-Hartley sponsor is
3 deemed to meet the requirement of paragraph (1).

4 “(3) TREATMENT OF CERTAIN QUALIFIED ASSOCIA-
5 TIONS.—An entity that is a qualified association is deemed
6 to meet the requirement of paragraph (1) with respect to
7 Medicare Choice products offered by such association and
8 issued by an organization to which subsection (b)(1) ap-
9 plies or by a provider-sponsored organization.

10 “(f) ORGANIZATIONS TREATED AS MEDICAREPLUS
11 ORGANIZATIONS DURING TRANSITION.—Any of the fol-
12 lowing organizations shall be considered to qualify as a
13 MedicarePlus organization for contract years beginning
14 before January 1, 1997:

15 “(1) HEALTH MAINTENANCE ORGANIZA-
16 TIONS.—An organization that is organized under the
17 laws of any State and that is a qualified health
18 maintenance organization (as defined in section
19 1310(d) of the Public Health Service Act), an orga-
20 nization recognized under State law as a health
21 maintenance organization, or a similar organization
22 regulated under State law for solvency in the same
23 manner and to the same extent as such a health
24 maintenance organization.

1 “(2) LICENSED INSURERS.—An organization
2 that is organized under the laws of any State and—

3 “(A) is licensed by a State agency as an
4 insurer for the offering of health benefit cov-
5 erage, or

6 “(B) is licensed by a State agency as a
7 service benefit plan,

8 but only for individuals residing in an area in which
9 the organization is licensed to offer health insurance
10 coverage.

11 “(3) CURRENT RISK-CONTRACTORS.—An orga-
12 nization that is an eligible organization (as defined
13 in section 1876(b)) and that has a risk-sharing con-
14 tract in effect under section 1876 as of the date of
15 the enactment of this section.

16 “REQUIREMENTS RELATING TO BENEFITS, PROVISION OF
17 SERVICES, ENROLLMENT, AND PREMIUMS

18 “SEC. 1852. (a) BENEFITS COVERED.—

19 “(1) IN GENERAL.—Each Medicare Choice
20 product offered under this part shall provide benefits
21 for at least the items and services for which benefits
22 are available under parts A and B consistent with
23 the standards for coverage of such items and serv-
24 ices applicable under this title.

25 “(2) ORGANIZATION AS SECONDARY PAYER.—
26 Notwithstanding any other provision of law, a Medi-

care Choice organization may (in the case of the provision of items and services to an individual under this part under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

“(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

“(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

“(3) SATISFACTION OF REQUIREMENT.—A Medicare Choice product offered by a Medicare Choice organization satisfies paragraph (1) with respect to benefits for items and services if the following requirements are met:

“(A) FEE FOR SERVICE PROVIDERS.—In the case of benefits furnished through a provider that does not have a contract with the organization, the product provides for at least the dollar amount of payment for such items and

1 services as would otherwise be provided under
2 parts A and B.

3 “(B) PARTICIPATING PROVIDERS.—In the
4 case of benefits furnished through a provider
5 that has such a contract, the individual’s liabil-
6 ity for payment for such items and services
7 does not exceed (after taking into account any
8 deductible, which does not exceed any deduct-
9 ible under parts A and B) the lesser of the fol-
10 lowing:

11 “(i) NON-MEDICARE CHOICE LIABIL-
12 ITY.—The amount of the liability that the
13 individual would have had (based on the
14 provider being a participating provider) if
15 the individual had elected the non-Medi-
16 care Choice option.

17 “(ii) MEDICARE COINSURANCE AP-
18 PLIED TO PRODUCT PAYMENT RATES.—
19 The applicable coinsurance or copayment
20 rate (that would have applied under the
21 non-Medicare Choice option) of the pay-
22 ment rate provided under the contract.

23 “(b) ANTIDISCRIMINATION.—A Medicare Choice or-
24 ganization may not deny, limit, or condition the coverage
25 or provision of benefits under this part based on the health

1 status, claims experience, receipt of health care, medical
2 history, or lack of evidence of insurability, of an individual.

3 “(c) GUARANTEED ISSUE AND RENEWAL.—

4 “(1) IN GENERAL.—Except as provided in this
5 subsection, a Medicare Choice organization shall
6 provide that at any time during which elections are
7 accepted under section 1805 with respect to a Medi-
8 care Choice product offered by the organization, the
9 organization will accept without restrictions individ-
10 uals who are eligible to make such election.

11 “(2) PRIORITY.—If the Secretary determines
12 that a Medicare Choice organization, in relation to
13 a Medicare Choice product it offers, has a capacity
14 limit and the number of eligible individuals who elect
15 the product under section 1805 exceeds the capacity
16 limit, the organization may limit the election of indi-
17 viduals of the product under such section but only
18 if priority in election is provided—

19 “(A) first to such individuals as have elect-
20 ed the product at the time of the determination,
21 and

22 “(B) then to other such individuals in such
23 a manner that does not discriminate among the
24 individuals (who seek to elect the product) on a
25 basis described in subsection (b).

1 “(3) LIMITATION ON TERMINATION OF ELEC-
2 TION.—

3 “(A) IN GENERAL.—Subject to subpara-
4 graph (B), a Medicare Choice organization may
5 not for any reason terminate the election of any
6 individual under section 1805 for a Medicare
7 Choice product it offers.

8 “(B) BASIS FOR TERMINATION OF ELEC-
9 TION.—A Medicare Choice organization may
10 terminate an individual’s election under section
11 1805 with respect to a Medicare Choice product
12 it offers if—

13 “(i) any premiums required with re-
14 spect to such product are not paid on a
15 timely basis (consistent with standards
16 under section 1856 that provide for a
17 grace period for late payment of pre-
18 miums),

19 “(ii) the individual has engaged in
20 disruptive behavior (as specified in such
21 standards), or

22 “(iii) the product is terminated with
23 respect to all individuals under this part.

24 Any individual whose election is so terminated
25 is deemed to have elected the Non-Medicare

1 Choice option (as defined in section
2 1805(a)(3)(A)).

3 “(C) ORGANIZATION OBLIGATION WITH RE-
4 SPECT TO ELECTION FORMS.—Pursuant to a con-
5 tract under section 1858, each Medicare Choice or-
6 ganization receiving an election form under section
7 1805(c)(2) shall transmit to the Secretary (at such
8 time and in such manner as the Secretary may
9 specify) a copy of such form or such other informa-
10 tion respecting the election as the Secretary may
11 specify.

12 “(4) SPECIAL RULES FOR LIMITED ENROLL-
13 MENT MEDICARE CHOICE ORGANIZATIONS.—

14 “(A) TAFT-HARTLEY SPONSORS.—

15 “(i) IN GENERAL.—Subject to sub-
16 paragraph (D), a Medicare Choice organi-
17 zation that is a Taft-Hartley sponsor (as
18 defined in clause (ii)) shall limit eligibility
19 of enrollees under this part for Medicare
20 Choice products it offers to individuals who
21 are entitled to obtain benefits through such
22 products under the terms of an applicable
23 collective bargaining agreement.

24 “(ii) TAFT-HARTLEY SPONSOR.—In
25 this part and section 1805, the term ‘Taft-

1 Hartley sponsor' means, in relation to a
 2 group health plan that is established or
 3 maintained by two or more employers or
 4 jointly by one or more employers and one
 5 or more employee organizations, the asso-
 6 ciation, committee, joint board of trustees,
 7 or other similar group of representatives of
 8 parties who establish or maintain the plan.

9 “(B) QUALIFIED ASSOCIATIONS.—

10 “(i) IN GENERAL.—Subject to sub-
 11 paragraph (D), a Medicare Choice organi-
 12 zation that is a qualified association (as
 13 defined in clause (iii)) shall limit eligibility
 14 of individuals under this part for products
 15 it offers to individuals who are members of
 16 the association (or who are spouses of such
 17 individuals).

18 “(ii) LIMITATION ON TERMINATION
 19 OF COVERAGE.—Such a qualifying associa-
 20 tion offering a Medicare Choice product to
 21 an individual may not terminate coverage
 22 of the individual on the basis that the indi-
 23 vidual is no longer a member of the asso-
 24 ciation except pursuant to a change of
 25 election during an open election period oc-

1 curring on or after the date of the termi-
2 nation of membership.

3 “(iii) QUALIFIED ASSOCIATION.—In
4 this part and section 1805, the term ‘quali-
5 fied association’ means an association, reli-
6 gious fraternal organization, or other orga-
7 nization (which may be a trade, industry,
8 or professional association, a chamber of
9 commerce, or a public entity association)
10 that the Secretary finds—

11 “(I) has been formed for pur-
12 poses other than the sale of any
13 health insurance and does not restrict
14 membership based on the health sta-
15 tus, claims experience, receipt of
16 health care, medical history, or lack of
17 evidence of insurability, of an individ-
18 ual,

19 “(II) does not exist solely or
20 principally for the purpose of selling
21 insurance, and

22 “(III) has at least 1,000 individ-
23 ual members or 200 employer mem-
24 bers.

1 Such term includes a subsidiary or cor-
2 poration that is wholly owned by one or
3 more qualified organizations.

4 “(C) UNIONS.—

5 “(i) IN GENERAL.—Subject to sub-
6 paragraph (D), a union sponsor (as de-
7 fined in clause (ii)) shall limit eligibility of
8 enrollees under this part for MedicarePlus
9 products it offers to individuals who are
10 members of the sponsor and affiliated with
11 the sponsor through an employment rela-
12 tionship with any employer or are the
13 spouses of such members.

14 “(ii) UNION SPONSOR.—In this part
15 and section 1805, the term ‘union sponsor’
16 means an employee organization in relation
17 to a group health plan that is established
18 or maintained by the organization other
19 than pursuant to a collective bargaining
20 agreement.

21 “(D) LIMITATION.—Rules of eligibility to
22 carry out the previous subparagraphs of this
23 paragraph shall not have the effect of denying
24 eligibility to individuals on the basis of health
25 status, claims experience, receipt of health care,

medical history, or lack of evidence of insurability.

“(E) LIMITED ENROLLMENT MEDICARE CHOICE ORGANIZATION.—In this part and section 1805, the term ‘limited enrollment Medicare Choice organization’ means a Medicare Choice organization that is a union sponsor, a Taft-Hartley sponsor, or a qualified association.

“(F) EMPLOYER, ETC.—In this paragraph, the terms ‘employer’, ‘employee organization’, and ‘group health plan’ have the meanings given such terms for purposes of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

“(d) SUBMISSION AND CHARGING OF PREMIUMS.—

“(1) IN GENERAL.—Each Medicare Choice organization shall file with the Secretary each year, in a form and manner and at a time specified by the Secretary—

“(A) the amount of the monthly premiums for coverage under each Medicare Choice product it offers under this part in each payment area (as determined for purposes of section 1855) in which the product is being offered; and

1 “(B) the enrollment capacity in relation to
2 the product in each such area.

3 “(2) AMOUNTS OF PREMIUMS CHARGED.—The
4 amount of the monthly premium charged by a Medi-
5 care Choice organization for a Medicare Choice
6 product offered in a payment area to an individual
7 under this part shall be equal to the amount (if any)
8 by which—

9 “(A) the amount of the monthly premium
10 for the product for the period involved, as es-
11 tablished under paragraph (3) and submitted
12 under paragraph (1), exceeds

13 “(B) $\frac{1}{12}$ of the annual Medicare Choice
14 capitation rate specified in section 1855(b)(2)
15 for the area and period involved.

16 “(3) UNIFORM PREMIUM.—The premiums
17 charged by a Medicare Choice organization under
18 this part may not vary among individuals who reside
19 in the same payment area.

20 “(4) TERMS AND CONDITIONS OF IMPOSING
21 PREMIUMS.—Each Medicare Choice organization
22 shall permit the payment of monthly premiums on a
23 monthly basis and may terminate election of individ-
24 uals for a Medicare Choice product for failure to

1 make premium payments only in accordance with
2 subsection (c)(3)(B).

3 “(5) RELATION OF PREMIUMS AND COST-SHAR-
4 ING TO BENEFITS.—In no case may the portion of
5 a Medicare Choice organization’s premium rate and
6 the actuarial value of its deductibles, coinsurance,
7 and copayments charged (to the extent attributable
8 to the minimum benefits described in subsection
9 (a)(1) and not counting any amount attributable to
10 balance billing) to individuals who are enrolled under
11 this part with the organization exceed the actuarial
12 value of the coinsurance and deductibles that would
13 be applicable on the average to individuals enrolled
14 under this part with the organization (or, if the Sec-
15 retary finds that adequate data are not available to
16 determine that actuarial value, the actuarial value of
17 the coinsurance and deductibles applicable on the av-
18 erage to individuals in the area, in the State, or in
19 the United States, eligible to enroll under this part
20 with the organization, or other appropriate data)
21 and entitled to benefits under part A and enrolled
22 under part B if they were not members of a Medi-
23 care Choice organization.

24 “(e) REQUIREMENT FOR ADDITIONAL BENEFITS,
25 PART B PREMIUM DISCOUNT REBATES, OR BOTH.—

1 “(1) REQUIREMENT.—

2 “(A) IN GENERAL.—Each Medicare Choice
3 organization (in relation to a Medicare Choice
4 product it offers) shall provide that if there is
5 an excess amount (as defined in subparagraph
6 (B)) for the product for a contract year, subject
7 to the succeeding provisions of this subsection,
8 the organization shall provide to individuals
9 such additional benefits (as the organization
10 may specify), a monetary rebate (paid on a
11 monthly basis) of the part B monthly premium,
12 or a combination thereof, in an total value
13 which is at least equal to the adjusted excess
14 amount (as defined in subparagraph (C)).

15 “(B) EXCESS AMOUNT.—For purposes of
16 this paragraph, the ‘excess amount’, for an or-
17 ganization for a product, is the amount (if any)
18 by which—

19 “(i) the average of the capitation pay-
20 ments made to the organization under this
21 part for the product at the beginning of
22 contract year, exceeds

23 “(ii) the actuarial value of the mini-
24 mum benefits described in subsection
25 (a)(1) under the product for individuals

under this part, as determined based upon an adjusted community rate described in paragraph (5) (as reduced for the actuarial value of the coinsurance and deductibles under parts A and B).

“(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the ‘adjusted excess amount’, for an organization for a product, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (3).

“(D) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a product in a service area.

“(E) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a Medicare Choice organization from providing health care benefits that are in addition to the benefits otherwise required to be provided under this paragraph and from imposing a premium for such additional benefits.

“(2) LIMITATION ON AMOUNT OF PART B PREMIUM DISCOUNT REBATE.—In no case shall the amount of a part B premium discount rebate under paragraph (1)(A) exceed, with respect to a month,

1 the amount of premiums imposed under part B (not
2 taking into account section 1839(b) (relating to pen-
3 alty for late enrollment) or 1839(h) (relating to af-
4 fluence testing)), for the individual for the month.
5 Except as provided in the previous sentence, a Medi-
6 care Choice organization is not authorized to provide
7 for cash or other monetary rebates as an inducement
8 for enrollment or otherwise.

9 “(3) STABILIZATION FUND.—A Medicare
10 Choice organization may provide that a part of the
11 value of an excess actuarial amount described in
12 paragraph (1) be withheld and reserved in the Fed-
13 eral Hospital Insurance Trust Fund and in the Fed-
14 eral Supplementary Medical Insurance Trust Fund
15 (in such proportions as the Secretary determines to
16 be appropriate) by the Secretary for subsequent an-
17 nual contract periods, to the extent required to sta-
18 bilize and prevent undue fluctuations in the addi-
19 tional benefits and rebates offered in those subse-
20 quent periods by the organization in accordance with
21 such paragraph. Any of such value of amount re-
22 served which is not provided as additional benefits
23 described in paragraph (1)(A) to individuals electing
24 the Medicare Choice product in accordance with

such paragraph prior to the end of such periods,
shall revert for the use of such trust funds.

“(4) DETERMINATION BASED ON INSUFFICIENT
DATA.—For purposes of this subsection, if the Sec-
retary finds that there is insufficient enrollment ex-
perience (including no enrollment experience in the
case of a provider-sponsored organization) to deter-
mine an average of the capitation payments to be
made under this part at the beginning of a contract
period, the Secretary may determine such an aver-
age based on the enrollment experience of other con-
tracts entered into under this part.

“(5) ADJUSTED COMMUNITY RATE.—

“(A) IN GENERAL.—For purposes of this
subsection, subject to subparagraph (B), the
term ‘adjusted community rate’ for a service or
services means, at the election of a Medicare
Choice organization, either—

“(i) the rate of payment for that serv-
ice or services which the Secretary annu-
ally determines would apply to an individ-
ual electing a Medicare Choice product
under this part if the rate of payment were
determined under a ‘community rating sys-
tem’ (as defined in section 1302(8) of the

1 Public Health Service Act, other than sub-
2 paragraph (C)), or

3 “(ii) such portion of the weighted ag-
4 gregate premium, which the Secretary an-
5 nually estimates would apply to such an in-
6 dividual, as the Secretary annually esti-
7 mates is attributable to that service or
8 services,

9 but adjusted for differences between the utiliza-
10 tion characteristics of the individuals electing
11 coverage under this part and the utilization
12 characteristics of the other enrollees with the
13 organization (or, if the Secretary finds that
14 adequate data are not available to adjust for
15 those differences, the differences between the
16 utilization characteristics of individuals select-
17 ing other Medicare Choice coverage, or individ-
18 uals in the area, in the State, or in the United
19 States, eligible to elect Medicare Choice cov-
20 erage under this part and the utilization char-
21 acteristics of the rest of the population in the
22 area, in the State, or in the United States, re-
23 spectively).

24 “(B) SPECIAL RULE FOR PROVIDER-SPON-
25 SORED ORGANIZATIONS.—In the case of a Med-

icare Choice organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a Medicare Choice product may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a product.

“(f) RULES REGARDING PHYSICIAN PARTICIPATION.—

“(1) PROCEDURES.—Each Medicare Choice organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under Medicare Choice products offered by the organization under this part. Such procedures shall include—

“(A) providing notice of the rules regarding participation,

“(B) providing written notice of participation decisions that are adverse to physicians, and

“(C) providing a process within the organization for appealing adverse decisions, including

1 the presentation of information and views of the
2 physician regarding such decision.

3 “(2) CONSULTATION IN MEDICAL POLICIES.—A
4 Medicare Choice organization shall consult with phy-
5 sicians who have entered into participation agree-
6 ments with the organization regarding the organiza-
7 tion’s medical policy, quality, and medical manage-
8 ment procedures.

9 “(3) LIMITATIONS ON PHYSICIAN INCENTIVE
10 PLANS.—

11 “(A) IN GENERAL.—Each Medicare Choice
12 organization may not operate any physician in-
13 centive plan (as defined in subparagraph (B))
14 unless the following requirements are met:

15 “(i) No specific payment is made di-
16 rectly or indirectly under the plan to a
17 physician or physician group as an induce-
18 ment to reduce or limit medically necessary
19 services provided with respect to a specific
20 individual enrolled with the organization.

21 “(ii) If the plan places a physician or
22 physician group at substantial financial
23 risk (as determined by the Secretary) for
24 services not provided by the physician or
25 physician group, the organization—

“(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

“(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

“(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

1 “(B) PHYSICIAN INCENTIVE PLAN DE-
2 FINED.—In this paragraph, the term ‘physician
3 incentive plan’ means any compensation ar-
4 rangement between a Medicare Choice organiza-
5 tion and a physician or physician group that
6 may directly or indirectly have the effect of re-
7 ducing or limiting services provided with respect
8 to individuals enrolled with the organization
9 under this part.

10 “(4) EXCEPTION FOR CERTAIN FEE-FOR-SERV-
11 ICE PLANS.—The previous provisions of this sub-
12 section shall not apply in the case of a Medicare
13 Choice organization in relation to a Medicare Choice
14 product if the organization does not have agree-
15 ments between physicians and the organization for
16 the provision of benefits under the product.

17 “(g) PROVISION OF INFORMATION.—A Medicare
18 Choice organization shall provide the Secretary with such
19 information on the organization and each Medicare Choice
20 product it offers as may be required for the preparation
21 of the information booklet described in section
22 1805(d)(3)(A).

23 “(h) COORDINATED ACUTE AND LONG-TERM CARE
24 BENEFITS UNDER A MEDICARE CHOICE PRODUCT.—
25 Nothing in this part shall be construed as preventing a

1 State from coordinating benefits under its medicaid pro-
 2 gram under title XIX with those provided under a Medi-
 3 care Choice product in a manner that assures continuity
 4 of a full-range of acute care and long-term care services
 5 to poor elderly or disabled individuals eligible for benefits
 6 under this title and under such program.

7 "PATIENT PROTECTION STANDARDS

8 "SEC. 1853. (a) DISCLOSURE TO ENROLLEES.—A
 9 Medicare Choice organization shall disclose in clear, accu-
 10 rate, and standardized form, information regarding all of
 11 the following for each Medicare Choice product it offers:

12 "(1) Benefits under the Medicare Choice prod-
 13 uct offered, including exclusions from coverage.

14 "(2) Rules regarding prior authorization or
 15 other review requirements that could result in
 16 nonpayment.

17 "(3) Potential liability for cost-sharing for out-
 18 of-network services.

19 "(4) The number, mix, and distribution of par-
 20 ticipating providers.

21 "(5) The financial obligations of the enrollee,
 22 including premiums, deductibles, co-payments, and
 23 maximum limits on out-of-pocket losses for items
 24 and services (both in and out of network).

1 “(6) Statistics on enrollee satisfaction with the
2 product and organization, including rates of
3 reenrollment.

4 “(7) Enrollee rights and responsibilities, includ-
5 ing the grievance process provided under subsection
6 (f).

7 “(8) A statement that the use of the 911 emer-
8 gency telephone number is appropriate in emergency
9 situations and an explanation of what constitutes an
10 emergency situation.

11 “(9) A description of the organization’s quality
12 assurance program under subsection (d).

13 Such information shall be disclosed to each enrollee under
14 this part at the time of enrollment and at least annually
15 thereafter.

16 “(b) ACCESS TO SERVICES.—

17 “(1) IN GENERAL.—A Medicare Choice organi-
18 zation offering a Medicare Choice product may re-
19 strict the providers from whom the benefits under
20 the product are provided so long as—

21 “(A) the organization makes such benefits
22 available and accessible to each individual elect-
23 ing the product within the product service area
24 with reasonable promptness and in a manner

1 which assures continuity in the provision of
2 benefits;

3 “(B) when medically necessary the organi-
4 zation makes such benefits available and acces-
5 sible 24 hours a day and 7 days a week;

6 “(C) the product provides for reimburse-
7 ment with respect to services which are covered
8 under subparagraphs (A) and (B) and which
9 are provided to such an individual other than
10 through the organization, if—

11 “(i) the services were medically nec-
12 essary and immediately required because of
13 an unforeseen illness, injury, or condition,
14 and

15 “(ii) it was not reasonable given the
16 circumstances to obtain the services
17 through the organization; and

18 “(D) coverage is provided for emergency
19 services (as defined in paragraph (5)) without
20 regard to prior authorization or the emergency
21 care provider’s contractual relationship with the
22 organization.

23 “(2) MINIMUM PAYMENT LEVELS WHERE PRO-
24 VIDING POINT-OF-SERVICE COVERAGE.—If a Medi-
25 care Choice product provides benefits for items and

1 services (not described in paragraph (1)(C)) through
 2 a network of providers and also permits payment to
 3 be made under the product for such items and serv-
 4 ices not provided through such a network, the pay-
 5 ment level under the product with respect to such
 6 items and services furnished outside the network
 7 shall be at least 70 percent (or, if the effective cost-
 8 sharing rate is 50 percent, at least 35 percent) of
 9 the lesser of—

10 “(A) the payment basis (determined with-
 11 out regard to deductibles and cost-sharing) that
 12 would have applied for such items and services
 13 under parts A and B, or

14 “(B) the amount charged by the entity fur-
 15 nishing such items and services.

16 “(3) PROTECTION OF ENROLLEES FOR CERTAIN
 17 OUT-OF-NETWORK SERVICES.—

18 “(A) PARTICIPATING PROVIDERS.—In the
 19 case of physicians’ services or renal dialysis
 20 services described in subparagraph (C) which
 21 are furnished by a participating physician or
 22 provider of services or renal dialysis facility to
 23 an individual enrolled with a MedicarePlus or-
 24 ganization under this section, the applicable
 25 participation agreement is deemed to provide

1 that the physician or provider of services or
2 renal dialysis facility will accept as payment in
3 full from the organization the amount that
4 would be payable to the physician or provider of
5 services or renal dialysis facility under part B
6 and from the individual under such part, if the
7 individual were not enrolled with such an orga-
8 nization under this part.

9 “(B) NONPARTICIPATING PROVIDERS.—In
10 the case of physicians’ services described in sub-
11 paragraph (C) which are furnished by a
12 nonparticipating physician, the limitations on
13 actual charges for such services otherwise appli-
14 cable under part B (to services furnished by in-
15 dividuals not enrolled with a MedicarePlus or-
16 ganization under this section) shall apply in the
17 same manner as such limitations apply to serv-
18 ices furnished to individuals not enrolled with
19 such an organization.

20 “(C) SERVICES DESCRIBED.—The physi-
21 cians’ services or renal dialysis services de-
22 scribed in this subparagraph are physicians’
23 services or renal dialysis services which are fur-
24 nished to an enrollee of a MedicarePlus organi-
25 zation under this part by a physician, provider

1 of services, or renal dialysis facility who is not
2 under a contract with the organization.

3 “(4) PROTECTION FOR NEEDED SERVICES.—A
4 Medicare Choice organization that provides covered
5 services through a network of providers shall provide
6 coverage of services provided by a provider that is
7 not part of the network if the service cannot be pro-
8 vided by a provider that is part of the network and
9 the organization authorized the service directly or
10 through referral by the primary care physician who
11 is designated by the organization for the individual
12 involved.

13 “(5) DEFINITION OF EMERGENCY SERVICES.—
14 In this subsection, the term ‘emergency services’
15 means, with respect to an individual enrolled with an
16 organization, covered inpatient and outpatient serv-
17 ices that—

18 “(A) are furnished by an appropriate
19 source other than the organization,

20 “(B) are needed immediately because of an
21 injury or sudden illness, and

22 “(C) are needed because the time required
23 to reach the organization’s providers or suppli-
24 ers would have meant risk of serious damage to
25 the patient’s health.

1 “(c) CONFIDENTIALITY AND ACCURACY OF EN-
2 ROLLEE RECORDS.—Each Medicare Choice organization
3 shall establish procedures—

4 “(1) to safeguard the privacy of individually
5 identifiable enrollee information, and

6 “(2) to maintain accurate and timely medical
7 records for enrollees.

8 “(d) QUALITY ASSURANCE PROGRAM.—

9 “(1) IN GENERAL.—Each Medicare Choice or-
10 ganization must have arrangements, established in
11 accordance with regulations of the Secretary, for an
12 ongoing quality assurance program for health care
13 services it provides to such individuals.

14 “(2) ELEMENTS OF PROGRAM.—The quality as-
15 surance program shall—

16 “(A) stress health outcomes;

17 “(B) provide for the establishment of writ-
18 ten protocols for utilization review, based on
19 current standards of medical practice;

20 “(C) provide review by physicians and
21 other health care professionals of the process
22 followed in the provision of such health care
23 services;

1 “(D) monitors and evaluates high volume
2 and high risk services and the care of acute and
3 chronic conditions;

4 “(E) evaluates the continuity and coordi-
5 nation of care that enrollees receive;

6 “(F) has mechanisms to detect both under-
7 utilization and overutilization of services;

8 “(G) after identifying areas for improve-
9 ment, establishes or alters practice parameters;

10 “(H) takes action to improve quality and
11 assesses the effectiveness of such action
12 through systematic follow-up;

13 “(I) makes available information on quality
14 and outcomes measures to facilitate beneficiary
15 comparison and choice of health coverage op-
16 tions (in such form and on such quality and
17 outcomes measures as the Secretary determines
18 to be appropriate);

19 “(J) is evaluated on an ongoing basis as to
20 its effectiveness; and

21 “(K) provide for external accreditation or
22 review, by a utilization and quality control peer
23 review organization under part B of title XI or
24 other qualified independent review organization,
25 of the quality of services furnished by the orga-

nization meets professionally recognized standards of health care (including providing adequate access of enrollees to services).

“(3) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—Paragraph (1) and subsection (c)(2) shall not apply in the case of a Medicare Choice organization in relation to a Medicare Choice product to the extent the organization provides for coverage of benefits without restrictions relating to utilization and without regard to whether the provider has a contract or other arrangement with the plan for the provision of such benefits.

“(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a Medicare Choice organization is deemed to meet the requirements of paragraphs (1) and (2) of this subsection and subsection (c) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization meets standards that are no less stringent than the standards established under section 1856 to carry out this subsection and subsection (c).

“(e) COVERAGE DETERMINATIONS.—

1 “(1) DECISIONS ON NONEMERGENCY CARE.—A
2 Medicare Choice organization shall make determina-
3 tions regarding authorization requests for non-
4 emergency care on a timely basis, depending on the
5 urgency of the situation.

6 “(2) APPEALS.—

7 “(A) IN GENERAL.—Appeals from a deter-
8 mination of an organization denying coverage
9 shall be decided within 30 days of the date of
10 receipt of medical information, but not later
11 than 60 days after the date of the decision.

12 “(B) PHYSICIAN DECISION ON CERTAIN
13 APPEALS.—Appeal decisions relating to a deter-
14 mination to deny coverage based on a lack of
15 medical necessity shall be made only by a physi-
16 cian.

17 “(C) EMERGENCY CASES.—Appeals from
18 such a determination involving a life-threaten-
19 ing or emergency situation shall be decided on
20 an expedited basis.

21 “(f) GRIEVANCES AND APPEALS.—

22 “(1) GRIEVANCE MECHANISM.—Each Medicare
23 Choice organization must provide meaningful proce-
24 dures for hearing and resolving grievances between
25 the organization (including any entity or individual

through which the organization provides health care services) and enrollees under this part.

“(2) APPEALS.—An enrollee with an organization under this part who is dissatisfied by reason of the enrollee’s failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is \$100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is \$1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary’s final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying sections 205(b) and 205(g) as provided in this subparagraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

1 “(3) COORDINATION WITH SECRETARY OF
2 LABOR.—The Secretary shall consult with the Sec-
3 retary of Labor so as to ensure that the require-
4 ments of this subsection, as they apply in the case
5 of grievances referred to in paragraph (1) to which
6 section 503 of the Employee Retirement Income Se-
7 curity Act of 1974 applies, are applied in a manner
8 consistent with the requirements of such section
9 503.

10 “(g) INFORMATION ON ADVANCE DIRECTIVES.—
11 Each Medicare Choice organization shall meet the require-
12 ment of section 1866(f) (relating to maintaining written
13 policies and procedures respecting advance directives).

14 “(h) APPROVAL OF MARKETING MATERIALS.—

15 “(1) SUBMISSION.—Each Medicare Choice or-
16 ganization may not distribute marketing materials
17 unless—

18 “(A) at least 45 days before the date of
19 distribution the organization has submitted the
20 material to the Secretary for review, and

21 “(B) the Secretary has not disapproved the
22 distribution of such material.

23 “(2) REVIEW.—The standards established
24 under section 1856 shall include guidelines for the
25 review of all such material submitted and under

such guidelines the Secretary shall disapprove such material if the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

“(3) DEEMED APPROVAL (1-STOP SHOPPING).—

In the case of material that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing materials under paragraph (1)(B) with respect to a Medicare Choice product in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the product and organization.

“(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each Medicare Choice organization shall conform to fair marketing standards in relation to Medicare Choice products offered under this part, included in the standards established under section 1856. Such standards shall include a prohibition against an organization (or agent of such an organization) completing any portion of any election form under section 1805 on behalf of any individual.

“(i) ADDITIONAL STANDARDIZED INFORMATION ON QUALITY, OUTCOMES, AND OTHER FACTORS.—

1 “(1) IN GENERAL.—In addition to any other in-
2 formation required to be provided under this part,
3 each Medicare Choice organization shall provide the
4 Secretary (at a time, not less frequently than annu-
5 ally, and in an electronic, standardized form and
6 manner specified by the Secretary) such information
7 as the Secretary determines to be necessary, consist-
8 ent with this part, to evaluate the performance of
9 the organization in providing benefits to enrollees.

10 “(2) INFORMATION TO BE INCLUDED.—Subject
11 to paragraph (3), information to be provided under
12 this subsection shall include at least the following:

13 “(A) Information on the characteristics of
14 enrollees that may affect their need for or use
15 of health services and the determination of risk-
16 adjusted payments under section 1855.

17 “(B) Information on the types of treat-
18 ments and outcomes of treatments with respect
19 to the clinical health, functional status, and
20 well-being of enrollees.

21 “(C) Information on health care expendi-
22 tures and the volume and prices of procedures.

23 “(D) Information on the flexibility per-
24 mitted by plans to enrollees in their selection of
25 providers.

“(3) SPECIAL TREATMENT.—The Secretary may waive the provision of such information under paragraph (2), or require such other information, as the Secretary finds appropriate in the case of a newly established Medicare Choice organization for which such information is not available.

“(j) DEMONSTRATION PROJECTS.—The Secretary shall provide for demonstration projects to determine the effectiveness, cost, and impact of alternative methods of providing comparative information about the performance of Medicare Choice organizations and products and the performance of medicare supplemental policies in relation to such products. Such projects shall include information about health care outcomes resulting from coverage under different products and policies.

“PROVIDER-SPONSORED ORGANIZATIONS

“SEC. 1854. (a) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

“(1) IN GENERAL.—In this part, the term ‘provider-sponsored organization’ means a public or private entity that (in accordance with standards established under subsection (b)) is a provider, or group of affiliated providers, that provides a substantial proportion (as defined by the Secretary under such standards) of the health care items and services

1 under the contract under this part directly through
2 the provider or affiliated group of providers.

3 “(2) SUBSTANTIAL PROPORTION.—In defining
4 what is a ‘substantial proportion’ for purposes of
5 paragraph (1), the Secretary—

6 “(A) shall take into account the need for
7 such an organization to assume responsibility
8 for a substantial proportion of services in order
9 to assure financial stability and the practical
10 difficulties in such an organization integrating
11 a very wide range of service providers; and

12 “(B) may vary such proportion based upon
13 relevant differences among organizations, such
14 as their location in an urban or rural area.

15 “(3) AFFILIATION.—For purposes of this sub-
16 section, a provider is ‘affiliated’ with another pro-
17 vider if, through contract, ownership, or otherwise—

18 “(A) one provider, directly or indirectly,
19 controls, is controlled by, or is under common
20 control with the other,

21 “(B) each provider is a participant in a
22 lawful combination under which each provider
23 shares, directly or indirectly, substantial finan-
24 cial risk in connection with their operations,

“(C) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

“(D) both providers are part of an affiliated service group under section 414 of such Code.

“(4) CONTROL.—For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

“(b) PREEMPTION OF STATE INSURANCE LICENSING REQUIREMENTS.—

“(1) IN GENERAL.—This section supersedes any State law which—

“(A) requires that a provider-sponsored organization meet requirements for insurers of health services or health maintenance organizations doing business in the State with respect to initial capitalization and establishment of financial reserves against insolvency, or

“(B) imposes requirements that would have the effect of prohibiting the organization

1 from complying with the applicable require-
 2 ments of this part,
 3 insofar as such the law applies to individuals en-
 4 rolled with the organization under this part.

5 “(2) EXCEPTION.—Paragraph (1) shall not
 6 apply with respect to any State law to the extent
 7 that such law provides standards or requirements, or
 8 provides for enforcement thereof, so as to meet the
 9 requirements of section 1857(b) with respect to ap-
 10 proval by the Secretary of State certification re-
 11 quirements thereunder.

12 “(3) CONSTRUCTION.—Nothing in this sub-
 13 section shall be construed as affecting the operation
 14 of section 514 of the Employee Retirement Income
 15 Security Act of 1974.

16 “PAYMENTS TO MEDICARE CHOICE ORGANIZATIONS

17 “SEC. 1855. (a) PAYMENTS.—

18 “(1) IN GENERAL.—Under a contract under
 19 section 1858 the Secretary shall pay to each Medi-
 20 care Choice organization, with respect to coverage of
 21 an individual under this part in a payment area for
 22 a month, an amount equal to the monthly adjusted
 23 Medicare Choice capitation rate (as provided under
 24 subsection (b)) with respect to that individual for
 25 that area.

“(2) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

“(A) the annual Medicare Choice capitation rate for each payment area for the year, and

“(B) the factors to be used in adjusting such rates under subsection (b) for payments for months in that year.

“(3) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (2) for a year, the Secretary shall provide for notice to Medicare Choice organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

“(4) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (2) for a year, the Secretary shall include an explanation of the assumptions (including any benefit coverage assump-

1 tions) and changes in methodology used in the an-
 2 nouncement in sufficient detail so that Medicare
 3 Choice organizations can compute monthly adjusted
 4 Medicare Choice capitation rates for classes of indi-
 5 viduals located in each payment area which is in
 6 whole or in part within the service area of such an
 7 organization.

8 “(b) MONTHLY ADJUSTED MEDICARE CHOICE CAPI-
 9 TATION RATE.—

10 “(1) IN GENERAL.—For purposes of this sec-
 11 tion, the ‘monthly adjusted Medicare Choice capita-
 12 tion rate’ under this subsection, for a month in a
 13 year for an individual in a payment area (specified
 14 under paragraph (3)) and in a class (established
 15 under paragraph (4)), is $\frac{1}{12}$ of the annual Medicare
 16 Choice capitation rate specified in paragraph (2) for
 17 that area for the year, adjusted to reflect the actuar-
 18 ial value of benefits under this title with respect to
 19 individuals in such class compared to the national
 20 average for individuals in all classes.

21 “(2) ANNUAL MEDICARE CHOICE CAPITATION
 22 RATES.—

23 “(A) IN GENERAL.—For purposes of this
 24 section, the annual Medicare Choice capitation
 25 rate for a payment area for a year is equal to

the annual Medicare Choice capitation rate for the area for the previous year (or, in the case of 1996, the average annual per capita rate of payment described in section 1876(a)(1)(C) for the area for 1995) increased by the per capita growth rate for that area and year (as determined under subsection (c)).

“(B) SPECIAL RULES FOR 1996.—

“(i) FLOOR AT 85 PERCENT OF NATIONAL AVERAGE.—In no case shall the annual Medicare Choice capitation rate for a payment area for 1996 be less than 85 percent of the national average of such rates for such year for all payment areas (weighted to reflect the number of medicare beneficiaries in each such area).

“(ii) REMOVAL OF MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—In determining the annual Medicare Choice capitation rate for 1996, the average annual per capita rate of payment described in section 1876(a)(1)(C) for 1995 shall be determined as though the

1 Secretary had excluded from such rate any
2 amounts which the Secretary estimated
3 would have been payable under this title
4 during the year for—

5 “(I) payment adjustments under
6 section 1886(d)(5)(F) for hospitals
7 serving a disproportionate share of
8 low-income patients; and

9 “(II) the indirect costs of medical
10 education under section
11 1886(d)(5)(B) or for direct graduate
12 medical education costs under section
13 1886(h).

14 “(3) PAYMENT AREA DEFINED.—

15 “(A) IN GENERAL.—In this section, the
16 term ‘payment area’ means—

17 “(i) a metropolitan statistical area, or

18 “(ii) all areas of a State outside of such an
19 area.

20 “(B) SPECIAL RULE FOR ESRD BENE-
21 FICIARIES.—Such term means, in the case of
22 the population group described in paragraph
23 (5)(C), each State.

24 “(4) CLASSES.—

“(A) IN GENERAL.—For purposes of this section, the Secretary shall define appropriate classes of enrollees, consistent with paragraph (5), based on age, gender, welfare status, institutionalization, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

“(B) RESEARCH.—The Secretary shall conduct such research as may be necessary to provide for greater accuracy in the adjustment of capitation rates under this subsection. Such research may include research into the addition or modification of classes under subparagraph (A). The Secretary shall submit to Congress a report on such research by not later than January 1, 1997.

“(5) DIVISION OF MEDICARE POPULATION.—In carrying out paragraph (4) and this section, the Secretary shall recognize the following separate population groups:

1 “(A) AGED.—Individuals 65 years of age
2 or older who are not described in subparagraph
3 (C).

4 “(B) DISABLED.—Disabled individuals
5 who are under 65 years of age and not de-
6 scribed in subparagraph (C).

7 “(C) INDIVIDUALS WITH END STAGE
8 RENAL DISEASE.—Individuals who are deter-
9 mined to have end stage renal disease.

10 “(c) PER CAPITA GROWTH RATES.—

11 “(1) FOR 1996.—

12 “(A) IN GENERAL.—For purposes of this
13 section and subject to subparagraph (B), the
14 per capita growth rates for 1996, for a payment
15 area assigned to a service utilization cohort
16 under subsection (d), shall be the following:

17 “(i) BELOW AVERAGE SERVICE UTILI-
18 ZATION COHORT.—For areas assigned to
19 the below average service utilization cohort,
20 11.5 percent.

21 “(ii) ABOVE AVERAGE SERVICE UTILI-
22 ZATION COHORT.—For areas assigned to
23 the above average service utilization co-
24 hort, 6.4 percent.

“(iii) HIGHEST SERVICE UTILIZATION
COHORT.—For areas assigned to the high-
est service utilization cohort, 3.2 percent.

“(B) BUDGET NEUTRAL ADJUSTMENT.—
The Secretary shall adjust the per capita
growth rates specified in subparagraph (A) for
all the areas by such uniform factor as may be
necessary to assure that the total capitation
payments under this section during 1996 are
the same as the amount such payments would
have been if the per capita growth rate for all
such areas for 1996 were equal to the national
average per capita growth rate, specified in
paragraph (3) for 1996.

“(2) FOR SUBSEQUENT YEARS.—

“(A) IN GENERAL.—For purposes of this
section and subject to subparagraph (B), the
Secretary shall compute a per capita growth
rate for each year after 1996, for each payment
area as assigned to a service utilization cohort
under subsection (d), consistent with the follow-
ing rules:

“(i) BELOW AVERAGE SERVICE UTILI-
ZATION COHORT SET AT 143 PERCENT OF
NATIONAL AVERAGE PER CAPITA GROWTH

1 RATE.—The per capita growth rate for
2 areas assigned to the below average service
3 utilization cohort for the year shall be 143
4 percent of the national average per capita
5 growth rate for the year (as specified
6 under paragraph (3)).

7 “(ii) ABOVE AVERAGE SERVICE UTILI-
8 ZATION COHORT SET AT 80 PERCENT OF
9 NATIONAL AVERAGE PER CAPITA GROWTH
10 RATE.—The per capita growth rate for
11 areas assigned to the above average service
12 utilization cohort for the year shall be 80
13 percent of the national average per capita
14 growth rate for the year.

15 “(iii) HIGHEST SERVICE UTILIZATION
16 COHORT SET AT 40 PERCENT OF NATIONAL
17 AVERAGE PER CAPITA GROWTH RATE.—
18 The per capita growth rate for areas as-
19 signed to the highest service utilization co-
20 hort for the year shall be 40 percent of the
21 national average per capita growth rate for
22 the year.

23 “(B) AVERAGE PER CAPITA GROWTH RATE
24 AT NATIONAL AVERAGE TO ASSURE BUDGET
25 NEUTRALITY.—The Secretary shall compute per

capita growth rates for a year under subparagraph (A) in a manner so that the weighted average per capita growth rate for all areas for the year (weighted to reflect the number of medicare beneficiaries in each area) is equal to the national average per capita growth rate under paragraph (3) for the year.

“(3) NATIONAL AVERAGE PER CAPITA GROWTH RATES.—In this subsection, the ‘national average per capita growth rate’ for—

“(A) 1996 is 8.0 percent,

“(B) 1997 is 7.5 percent,

“(C) 1998 is 7.0 percent,

“(D) 1999 is 7.0 percent,

“(E) 2000 is 7.0 percent,

“(F) 2001 is 7.0 percent,

“(G) 2002 is 6.0 percent, and

“(H) each subsequent year is 6.0 percent.

“(d) ASSIGNMENT OF PAYMENT AREAS TO SERVICE UTILIZATION COHORTS.—

“(1) IN GENERAL.—For purposes of determining per capita growth rates under subsection (c) for areas for a year, the Secretary shall assign each payment area to a service utilization cohort (based on

1 the service utilization index value for that area de-
2 termined under paragraph (2)) as follows:

3 “(A) BELOW AVERAGE SERVICE UTILIZA-
4 TION COHORT.—Areas with a service utilization
5 index value of less than 1.00 shall be assigned
6 to the below average service utilization cohort.

7 “(B) ABOVE AVERAGE SERVICE UTILIZA-
8 TION COHORT.—Areas with a service utilization
9 index value of at least 1.00 but less than 1.20
10 shall be assigned to the above average service
11 utilization cohort.

12 “(C) HIGHEST SERVICE UTILIZATION CO-
13 HORT.—Areas with a service utilization index
14 value of at least 1.20 shall be assigned to the
15 highest service utilization cohort.

16 “(2) DETERMINATION OF SERVICE UTILIZATION
17 INDEX VALUES.—In order to determine the per cap-
18 ita growth rate for a payment area for each year
19 (beginning with 1996), the Secretary shall determine
20 for such area and year a service utilization index
21 value, which is equal to—

22 “(A) the annual Medicare Choice capita-
23 tion rate under this section for the area for the
24 year in which the determination is made (or, in
25 the case of 1996, the average annual per capita

rate of payment (described in section 1876(a)(1)(C)) for the area for 1995); divided by

“(B) the input-price-adjusted annual national Medicare Choice capitation rate (as determined under paragraph (3)) for that area for the year in which the determination is made.

“(3) DETERMINATION OF INPUT-PRICE-ADJUSTED RATES.—

“(A) IN GENERAL.—For purposes of paragraph (2), the ‘input-price-adjusted annual national Medicare Choice capitation rate’ for a payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type) of—

“(i) the national standardized Medicare Choice capitation rate (determined under subparagraph (B)) for the year,

“(ii) the proportion of such rate for the year which is attributable to such type of services, and

“(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area

1 compared to the national average input
2 price of such services.

3 In applying clause (iii), the Secretary shall, sub-
4 ject to subparagraph (C), apply those indices
5 under this title that are used in applying (or
6 updating) national payment rates for specific
7 areas and localities.

8 “(B) NATIONAL STANDARDIZED MEDICARE
9 CHOICE CAPITATION RATE.—In this paragraph,
10 the ‘national standardized Medicare Choice
11 capitation rate’ for a year is equal to—

12 “(i) the sum (for all payment areas)
13 of the product of (I) the annual Medicare
14 Choice capitation rate for that year for the
15 area under subsection (b)(2), and (II) the
16 average number of medicare beneficiaries
17 residing in that area in the year; divided
18 by

19 “(ii) the total average number of med-
20 icare beneficiaries residing in all the pay-
21 ment areas for that year.

22 “(C) SPECIAL RULES FOR 1996.—In apply-
23 ing this paragraph for 1996—

“(i) medicare services shall be divided into 2 types of services: part A services and part B services;

“(ii) the proportions described in subparagraph (A)(ii) for such types of services shall be—

“(I) for part A services, the ratio (expressed as a percentage) of the average annual per capita rate of payment for the area for part A for 1995 to the total average annual per capita rate of payment for the area for parts A and B for 1995, and

“(II) for part B services, 100 percent minus the ratio described in subclause (I);

“(iii) for the part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

“(iv) for part B services—

1 “(I) 66 percent of payments at-
2 tributable to such services shall be ad-
3 justed by the index of the geographic
4 area factors under section 1848(e)
5 used to adjust payment rates for phy-
6 sicians’ services furnished in the pay-
7 ment area, and

8 “(II) of the remaining 34 percent
9 of the amount of such payments, 70
10 percent shall be adjusted by the index
11 described in clause (iii);

12 “(v) the index values shall be com-
13 puted based only on the beneficiary popu-
14 lation described in subsection (b)(5)(A).

15 The Secretary may continue to apply the rules
16 described in this subparagraph (or similar
17 rules) for 1997.

18 “(e) PAYMENT PROCESS.—

19 “(1) IN GENERAL.—Subject to section 1859(f),
20 the Secretary shall make monthly payments under
21 this section in advance and in accordance with the
22 rate determined under subsection (a) to the plan for
23 each individual enrolled with a Medicare Choice or-
24 ganization under this part.

“(2) ADJUSTMENT TO REFLECT NUMBER OF
ENROLLEES.—

“(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

“(B) SPECIAL RULE FOR CERTAIN EN-
ROLLEES.—

“(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare Choice organization under a product operated, sponsored, or contributed to by the individual’s employer or former employer (or the employer or former employer of the individual’s spouse) and ending on the date on which the individual is enrolled in the organization under this part, except

1 that for purposes of making such retro-
 2 active adjustments under this subpara-
 3 graph, such period may not exceed 90
 4 days.

5 “(ii) EXCEPTION.—No adjustment
 6 may be made under clause (i) with respect
 7 to any individual who does not certify that
 8 the organization provided the individual
 9 with the disclosure statement described in
 10 section 1853(a) at the time the individual
 11 enrolled with the organization.

12 “(f) PAYMENTS FROM TRUST FUND.—The payment
 13 to a Medicare Choice organization under this section for
 14 individuals enrolled under this part with the organization,
 15 and payments to a Medicare Choice MSA under subsection
 16 (f)(1)(B), shall be made from the Federal Hospital Insur-
 17 ance Trust Fund and the Federal Supplementary Medical
 18 Insurance Trust Fund in such proportion as the Secretary
 19 determines reflects the relative weight that benefits under
 20 part A and under part B represents of the actuarial value
 21 of the total benefits under this title.

22 “(g) SPECIAL RULE FOR CERTAIN INPATIENT HOS-
 23 PITAL STAYS.—In the case of an individual who is receiv-
 24 ing inpatient hospital services from a subsection (d) hos-

1 pital (as defined in section 1886(d)(1)(B)) as of the effec-
2 tive date of the individual's—

3 “(1) election under this part of a Medicare
4 Choice product offered by a Medicare Choice organi-
5 zation—

6 “(A) payment for such services until the
7 date of the individual's discharge shall be made
8 under this title through the Medicare Choice
9 product or Non-Medicare Choice option (as the
10 case may be) elected before the election with
11 such organization,

12 “(B) the elected organization shall not be
13 financially responsible for payment for such
14 services until the date after the date of the indi-
15 vidual's discharge, and

16 “(C) the organization shall nonetheless be
17 paid the full amount otherwise payable to the
18 organization under this part; or

19 “(2) termination of election with respect to a
20 Medicare Choice organization under this part—

21 “(A) the organization shall be financially
22 responsible for payment for such services after
23 such date and until the date of the individual's
24 discharge,

1 “(B) payment for such services during the
2 stay shall not be made under section 1886(d) or
3 by any succeeding Medicare Choice organiza-
4 tion, and

5 “(C) the terminated organization shall not
6 receive any payment with respect to the individ-
7 ual under this part during the period the indi-
8 vidual is not enrolled.

9 “ESTABLISHMENT OF STANDARDS FOR MEDICARE
10 CHOICE ORGANIZATIONS AND PRODUCTS

11 “SEC. 1856. (a) INTERIM STANDARDS.—

12 “(1) IN GENERAL.—The Secretary shall issue
13 regulations regarding standards for Medicare Choice
14 organizations and products within 180 days after
15 the date of the enactment of this section. Such regu-
16 lations shall be issued on an interim basis, but shall
17 become effective upon publication and shall be effec-
18 tive through the end of 1999.

19 “(2) SOLICITATION OF VIEWS.—In developing
20 standards under this subsection relating to solvency
21 of Medicare Choice organizations, the Secretary shall
22 solicit the views of the American Academy of Actu-
23 aries.

24 “(3) EFFECT ON STATE REGULATIONS.—Regu-
25 lations under this subsection shall not preempt State

regulations for Medicare Choice organizations for products not offered under this part.

“(b) PERMANENT STANDARDS.—

“(1) IN GENERAL.—The Secretary shall develop permanent standards under this subsection.

“(2) CONSULTATION.—In developing standards under this subsection, the Secretary shall consult with the National Association of Insurance Commissioners, associations representing the various types of Medicare Choice organizations, and medicare beneficiaries.

“(3) EFFECTIVENESS.—The standards under this subsection shall take effect for periods beginning on or after January 1, 2000.

“(c) SOLVENCY.—In establishing interim and permanent standards under this section relating to solvency of organizations, the Secretary shall recognize the multiple means of demonstrating solvency, including—

“(1) reinsurance purchased through a recognized commerce company or through a captive company owned directly or indirectly by 3 or more provider-sponsored organizations,

“(2) unrestricted surplus,

“(3) guarantees, and

“(4) letters of credit.

1 In such standards, the Secretary may treat as admitted
2 assets the assets used by a provider-sponsored organiza-
3 tion in delivering covered services.

4 “(d) APPLICATION OF NEW STANDARDS TO ENTI-
5 TIES WITH A CONTRACT.—In the case of a Medicare
6 Choice organization with a contract in effect under this
7 part at the time standards applicable to the organization
8 under this section are changed, the organization may elect
9 not to have such changes apply to the organization until
10 the end of the current contract year (or, if there is less
11 than 6 months remaining in the contract year, until 1 year
12 after the end of the current contract year).

13 “(e) RELATION TO STATE LAWS.—The standards es-
14 tablished under this section shall supersede any State law.
15 The standard or regulation with respect to Medicare
16 Choice products which are offered by Medicare Choice or-
17 ganizations and are issued by organizations to which sec-
18 tion 1851(b)(1) applies, to the extent such law or regula-
19 tion is inconsistent with such standards.

20 “MEDICARE CHOICE CERTIFICATION

21 “SEC. 1857. (a) IN GENERAL.—

22 “(1) ESTABLISHMENT.—The Secretary shall es-
23 tablish a process for the certification of organiza-
24 tions and products offered by organizations as meet-
25 ing the applicable standards for Medicare Choice or-

ganizations and Medicare Choice products established under section 1856.

“(2) INVOLVEMENT OF SECRETARY OF LABOR.—Such process shall be established and operated in cooperation with the Secretary of Labor with respect to union sponsors and Taft-Hartley sponsors.

“(3) USE OF STATE LICENSING AND PRIVATE ACCREDITATION PROCESSES.—

“(A) IN GENERAL.—The process under this subsection shall, to the maximum extent practicable, provide that Medicare Choice organizations and products that are licensed or certified through a qualified private accreditation process that the Secretary finds applies standards that are no less stringent than the requirements of this part are deemed to meet the corresponding requirements of this part for such an organization or product.

“(B) PERIODIC ACCREDITATION.—The use of an accreditation under subparagraph (A) shall be valid only for such period as the Secretary specifies.

“(4) USER FEES.—The Secretary may impose user fees on entities seeking certification under this

1 subsection in such amounts as the Secretary deems
2 sufficient to finance the costs of such certification.

3 “(b) STATE CERTIFICATION PROCESS.—

4 “(1) APPROVAL OF STATE PROCESS.—Effective
5 for periods beginning on or after January 1, 2000,
6 the Secretary shall approve a Medicare Choice cer-
7 tification and enforcement program established by a
8 State for applying the standards established under
9 section 1856 to Medicare Choice organizations and
10 Medicare Choice products offered by such organiza-
11 tions if the Secretary determines that the program
12 fairly and efficiently provides for the application and
13 enforcement of such standards in the State with re-
14 spect to such organizations and products and such
15 program does not provide for the imposition (for or-
16 ganizations only offering products under this part)
17 of any standards in addition to the standards pro-
18 vided under section 1856. Such program shall pro-
19 vide for certification of compliance of Medicare
20 Choice organizations and products with the applica-
21 ble requirements of this part not less often than
22 once every 3 years.

23 “(2) EFFECT OF CERTIFICATION UNDER STATE
24 PROCESS.—A Medicare Choice organization and
25 Medicare Choice product offered by such an organi-

1 zation that is certified under such program is con-
2 sidered to have been certified under this subsection
3 with respect to the offering of the product to individ-
4 uals residing in the State.

5 “(3) USER FEES.—The State may impose user
6 fees on organizations seeking certification under this
7 subsection in such amounts as the State deems suffi-
8 cient to finance the costs of such certification. Noth-
9 ing in this paragraph shall be construed as restrict-
10 ing a State’s authority to impose premium taxes,
11 other taxes, or other levies.

12 “(4) REVIEW.—The Secretary periodically shall
13 review State programs approved under paragraph
14 (1) to determine if they continue to provide for the
15 fair and efficient certification and enforcement de-
16 scribed in such paragraph. If the Secretary finds
17 that a State program no longer so provides, before
18 making a final determination, the Secretary shall
19 provide the State an opportunity to adopt such a
20 plan of correction as would permit the State pro-
21 gram to meet the requirements of paragraph (1). If
22 the Secretary makes a final determination that the
23 State program, after such an opportunity, fails to
24 meet such requirements, the provisions of paragraph

1 (2) shall no longer apply to Medicare Choice organi-
2 zations and products in the State.

3 “(5) PUBLICATION OF LIST OF APPROVED
4 STATE PROGRAMS.—The Secretary shall publish
5 (and periodically update) a list of those State pro-
6 grams which are approved for purposes of this sub-
7 section.

8 “(c) NOTICE TO ENROLLEES IN CASE OF DECERTI-
9 FICATION.—If a Medicare Choice organization or product
10 is decertified under this section, the organization shall no-
11 tify each enrollee with the organization and product under
12 this part of such decertification.

13 “(d) QUALIFIED ASSOCIATIONS.—In the case of Med-
14 icare Choice products offered by a Medicare Choice orga-
15 nization that is a qualified association (as defined in sec-
16 tion 1854(c)(4)(C)) and issued by an organization to
17 which section 1851(b)(1) applies or by a provider-spon-
18 sored organization (as defined in section 1854(a)), nothing
19 in this section shall be construed as limiting the authority
20 of States to regulate such products.

21 “CONTRACTS WITH MEDICARE CHOICE ORGANIZATIONS
22 “SEC. 1858. (a) IN GENERAL.—The Secretary shall
23 not permit the election under section 1805 of a Medicare
24 Choice product offered by a Medicare Choice organization
25 under this part, and no payment shall be made under sec-
26 tion 1856 to an organization, unless the Secretary has en-

1 tered into a contract under this section with an organiza-
 2 tion with respect to the offering of such product. Such
 3 a contract with an organization may cover more than one
 4 Medicare Choice product. Such contract shall provide that
 5 the organization agrees to comply with the applicable re-
 6 quirements and standards of this part and the terms and
 7 conditions of payment as provided for in this part.

8 “(b) ENROLLMENT REQUIREMENTS.—

9 “(A) MINIMUM ENROLLMENT REQUIRE-
 10 MENT.—Subject to subparagraphs (B) and (C),
 11 the Secretary may not enter into a contract
 12 under this section with a Medicare Choice orga-
 13 nization (other than a union sponsor or Taft-
 14 Hartley sponsor) unless the organization has at
 15 least 5,000 individuals (or 1,500 individuals in
 16 the case of an organization that is a provider-
 17 sponsored organization) who are receiving
 18 health benefits through the organization, except
 19 that the standards under section 1856 may per-
 20 mit the organization to have a lesser number of
 21 beneficiaries (but not less than 500 in the case
 22 of an organization that is a provider-sponsored
 23 organization) if the organization primarily
 24 serves individuals residing outside of urbanized
 25 areas.

1 “(B) ALLOWING TRANSITION.—The Sec-
2 retary may waive the requirement of subpara-
3 graph (A) during the first 3 contract years with
4 respect to an organization.

5 “(C) TREATMENT OF AREAS WITH LOW
6 MANAGED CARE PENETRATION.—The Secretary
7 may waive the requirement of subparagraph (A)
8 in the case of organizations operating in areas
9 in which there is a low proportion of medicare
10 beneficiaries who have made the Medicare
11 Choice election.

12 “(2) REQUIREMENT FOR ENROLLMENT OF
13 NON-MEDICARE BENEFICIARIES.—

14 “(A) IN GENERAL.—Each Medicare Choice
15 organization with which the Secretary enters
16 into a contract under this section shall have, for
17 the duration of such contract, an enrolled mem-
18 bership at least one-half of which consists of in-
19 dividuals who are not entitled to benefits under
20 this title or under a State plan approved under
21 title XIX.

22 “(B) EXCEPTION.—Subparagraph (A)
23 shall not apply to—

24 “(i) an organization that has been
25 certified by a national organization recog-

nized by the Secretary and has been found to have met performance standards established by the Secretary for at least 2 years, or

“(ii) a provider-sponsored organization for which commercial payments to providers participating in the organization exceed the payments to the organization under this part.

“(C) MODIFICATION AND WAIVER.—The Secretary may modify or waive the requirement imposed by subparagraph (A)—

“(i) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX, or

“(ii) in the case of an organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable

1 efforts to enroll individuals who are not en-
2 titled to benefits under this title or under
3 a State plan approved under title XIX.

4 “(D) ENFORCEMENT.—If the Secretary
5 determines that an organization has failed to
6 comply with the requirements of this para-
7 graph, the Secretary may provide for the sus-
8 pension of enrollment of individuals under this
9 part or of payment to the organization under
10 this part for individuals newly enrolled with the
11 organization, after the date the Secretary noti-
12 fies the organization of such noncompliance.

13 “(e) CONTRACT PERIOD AND EFFECTIVENESS.—

14 “(1) PERIOD.—Each contract under this sec-
15 tion shall be for a term of at least one year, as de-
16 termined by the Secretary, and may be made auto-
17 matically renewable from term to term in the ab-
18 sence of notice by either party of intention to termi-
19 nate at the end of the current term.

20 “(2) TERMINATION AUTHORITY.—In accord-
21 ance with procedures established under subsection
22 (h), the Secretary may at any time terminate any
23 such contract or may impose the intermediate sanc-
24 tions described in an applicable paragraph of sub-

section (g) on the Medicare Choice organization if the Secretary determines that the organization—

“(A) has failed substantially to carry out the contract;

“(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part;

“(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

“(D) no longer substantially meets the applicable conditions of this part.

“(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract.

“(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a Medicare Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

“(5) NO CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be

1 performed without regard to such provisions of law
2 or regulations relating to the making, performance,
3 amendment, or modification of contracts of the
4 United States as the Secretary may determine to be
5 inconsistent with the furtherance of the purpose of
6 this title.

7 “(d) PROTECTIONS AGAINST FRAUD AND BENE-
8 FICIARY PROTECTIONS.—

9 “(1) INSPECTION AND AUDIT.—Each contract
10 under this section shall provide that the Secretary,
11 or any person or organization designated by the Sec-
12 retary—

13 “(A) shall have the right to inspect or oth-
14 erwise evaluate (i) the quality, appropriateness,
15 and timeliness of services performed under the
16 contract and (ii) the facilities of the organiza-
17 tion when there is reasonable evidence of some
18 need for such inspection, and

19 “(B) shall have the right to audit and in-
20 spect any books and records of the Medicare
21 Choice organization that pertain (i) to the abil-
22 ity of the organization to bear the risk of poten-
23 tial financial losses, or (ii) to services performed
24 or determinations of amounts payable under the
25 contract.

“(2) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract’s termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

“(3) DISCLOSURE.—

“(A) IN GENERAL.—Each Medicare Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

“(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

“(ii) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 by disclosing entities.

“(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

1 “(I) any sale or exchange, or
2 leasing of any property between the
3 organization and a party in interest;

4 “(II) any furnishing for consider-
5 ation of goods, services (including
6 management services), or facilities be-
7 tween the organization and a party in
8 interest, but not including salaries
9 paid to employees for services pro-
10 vided in the normal course of their
11 employment and health services pro-
12 vided to members by hospitals and
13 other providers and by staff, medical
14 group (or groups), individual practice
15 association (or associations), or any
16 combination thereof; and

17 “(III) any lending of money or
18 other extension of credit between an
19 organization and a party in interest.

20 The Secretary may require that information re-
21 ported respecting an organization which con-
22 trols, is controlled by, or is under common con-
23 trol with, another entity be in the form of a
24 consolidated financial statement for the organi-
25 zation and such entity.

“(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term ‘party in interest’ means—

“(i) any director, officer, partner, or employee responsible for management or administration of a Medicare Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

“(ii) any entity in which a person described in clause (i)—

“(I) is an officer or director;

“(II) is a partner (if such entity is organized as a partnership);

“(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

1 “(IV) has a mortgage, deed of
2 trust, note, or other interest valuing
3 more than 5 percent of the assets of
4 such entity;

5 “(iii) any person directly or indirectly
6 controlling, controlled by, or under com-
7 mon control with an organization; and

8 “(iv) any spouse, child, or parent of
9 an individual described in clause (i).

10 “(C) ACCESS TO INFORMATION.—Each
11 Medicare Choice organization shall make the in-
12 formation reported pursuant to subparagraph
13 (A) available to its enrollees upon reasonable
14 request.

15 “(4) LOAN INFORMATION.—The contract shall
16 require the organization to notify the Secretary of
17 loans and other special financial arrangements which
18 are made between the organization and subcontract-
19 tors, affiliates, and related parties.

20 “(f) ADDITIONAL CONTRACT TERMS.—The contract
21 shall contain such other terms and conditions not incon-
22 sistent with this part (including requiring the organization
23 to provide the Secretary with such information) as the
24 Secretary may find necessary and appropriate.

25 “(g) INTERMEDIATE SANCTIONS.—

“(1) IN GENERAL.—If the Secretary determines that a Medicare Choice organization with a contract under this section—

“(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

“(B) imposes premiums on individuals enrolled under this part in excess of the premiums permitted;

“(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

“(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

“(E) misrepresents or falsifies information that is furnished—

1 “(i) to the Secretary under this part,
2 or

3 “(ii) to an individual or to any other
4 entity under this part;

5 “(F) fails to comply with the requirements
6 of section 1852(f)(3); or

7 “(G) employs or contracts with any indi-
8 vidual or entity that is excluded from participa-
9 tion under this title under section 1128 or
10 1128A for the provision of health care, utiliza-
11 tion review, medical social work, or administra-
12 tive services or employs or contracts with any
13 entity for the provision (directly or indirectly)
14 through such an excluded individual or entity of
15 such services;

16 the Secretary may provide, in addition to any other
17 remedies authorized by law, for any of the remedies
18 described in paragraph (2).

19 “(2) REMEDIES.—The remedies described in
20 this paragraph are—

21 “(A) civil money penalties of not more
22 than \$25,000 for each determination under
23 paragraph (1) or, with respect to a determina-
24 tion under subparagraph (D) or (E)(i) of such
25 paragraph, of not more than \$100,000 for each

such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), \$15,000 for each individual not enrolled as a result of the practice involved,

“(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

“(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

“(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a Medicare Choice organization for which

1 the Secretary makes a determination under sub-
 2 section (c)(2) the basis of which is not described in
 3 paragraph (1), the Secretary may apply the follow-
 4 ing intermediate sanctions:

5 “(A) civil money penalties of not more
 6 than \$25,000 for each determination under
 7 subsection (c)(2) if the deficiency that is the
 8 basis of the determination has directly adversely
 9 affected (or has the substantial likelihood of ad-
 10 versely affecting) an individual covered under
 11 the organization’s contract;

12 “(B) civil money penalties of not more
 13 than \$10,000 for each week beginning after the
 14 initiation of procedures by the Secretary under
 15 subsection (h) during which the deficiency that
 16 is the basis of a determination under subsection
 17 (c)(2) exists; and

18 “(C) suspension of enrollment of individ-
 19 uals under this part after the date the Sec-
 20 retary notifies the organization of a determina-
 21 tion under subsection (c)(2) and until the Sec-
 22 retary is satisfied that the deficiency that is the
 23 basis for the determination has been corrected
 24 and is not likely to recur.

“(4) PROCEDURES FOR IMPOSING SANCTIONS.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (1) or (2) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

“(h) PROCEDURES FOR IMPOSING SANCTIONS.—The Secretary may terminate a contract with a Medicare Choice organization under this section or may impose the intermediate sanctions described in subsection (g) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

“(1) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary’s determination under subsection (c)(2);

“(2) the Secretary shall impose more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

1 “(3) there are no unreasonable or unnecessary
2 delays between the finding of a deficiency and the
3 imposition of sanctions; and

4 “(4) the Secretary provides the organization
5 with reasonable notice and opportunity for hearing
6 (including the right to appeal an initial decision) be-
7 fore imposing any sanction or terminating the con-
8 tract.

9 “DEMONSTRATION PROJECT FOR HIGH DEDUCTIBLE/
10 MEDISAVE PRODUCTS

11 “SEC. 1859. (a) IN GENERAL.—The Secretary shall
12 permit, on a demonstration project basis, the offering of
13 high deductible/medisave products under this part, subject
14 to the special rules provided under this section.

15 “(b) HIGH DEDUCTIBLE/MEDISAVE PRODUCT DE-
16 FINED.—

17 “(1) IN GENERAL.—In this part, the term ‘high
18 deductible/medisave product’ means a Medicare
19 Choice product that—

20 “(A) provides reimbursement for at least
21 the items and services described in section
22 1852(a)(1) in a year but only after the enrollee
23 incurs countable expenses (as specified under
24 the product) equal to the amount of a deduct-
25 ible (described in paragraph (2));

“(B) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B or by the enrollee if the enrollee had elected to receive benefits through the provisions of such parts; and

“(C) provides, after such deductible is met for a year and for all subsequent expenses for benefits referred to in subparagraph (A) in the year, for a level of reimbursement that is not less than—

“(i) 100 percent of such expenses, or

“(ii) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less. Such term does not include the Medicare Choice MSA itself or any contribution into such account.

“(2) DEDUCTIBLE.—The amount of deductible under a high deductible/medisave product—

“(A) for contract year 1997 shall be not more than \$10,000; and

1 “(B) for a subsequent contract year shall
2 be not more than the maximum amount of such
3 deductible for the previous contract year under
4 this paragraph increased by the national aver-
5 age per capita growth rate under section
6 1855(c)(3) for the year.

7 If the amount of the deductible under subparagraph
8 (B) is not a multiple of \$50, the amount shall be
9 rounded to the nearest multiple of \$50.

10 “(c) SPECIAL RULES RELATING TO ENROLLMENT.—
11 The rule under section 1805 relating to election of Medi-
12 care Choice products shall apply to election of high deduct-
13 ible/medisave products offered under the demonstration
14 project under this section, except as follows:

15 “(1) SPECIAL RULE FOR CERTAIN ANNU-
16 ITANTS.—An individual is not eligible to elect a high
17 deductible/medisave product under section 1805 if
18 the individual is entitled to benefits under chapter
19 89 of title 5, United States Code, as an annuitant
20 or spouse of an annuitant.

21 “(2) TRANSITION PERIOD RULE.—During the
22 transition period (as defined in section
23 1805(e)(1)(B)), an individual who has elected a high
24 deductible/medisave product may not change such
25 election to a Medicare Choice product that is not a

high deductible/medisave product unless the individual has had such election in effect for 12 months.

“(3) NO 90-DAY DISENROLLMENT OPTION.—Paragraph (4)(A) of section 1805(e) shall not apply to an individual who elects a high deductible/medisave product.

“(4) TIMING OF ELECTION.—An individual may elect a high deductible/medisave product only during an annual, coordinated election period described in section 1805(e)(3)(B) or during the month of October, 1996.

“(5) EFFECTIVENESS OF ELECTION.—An election of coverage for a high deductible/medisave product made in a year shall take effect as of the first day of the following year.

“(d) SPECIAL RULES RELATING TO BENEFITS.—

“(1) IN GENERAL.—Paragraphs (1) and (3) of section 1852(a) shall not apply to high deductible/medisave products.

“(2) PREMIUMS.—

“(A) APPLICATION OF ALTERNATIVE PREMIUM.—In applying section 1852(d)(2) in the case of a high deductible/medisave product, instead of the amount specified in subparagraph (B) there shall be substituted the monthly ad-

1 justed Medicare Choice capitation rate specified
2 in section 1855(b)(1) for the individual and pe-
3 riod involved.

4 “(B) CLASS ADJUSTED PREMIUMS.—Not-
5 withstanding section 1852(d)(3), a Medicare
6 Choice organization shall establish premiums
7 for any high deductible/medisave product it of-
8 fers in a payment area based on each of the
9 risk adjustment categories established for pur-
10 poses of determining the amount of the pay-
11 ment to Medicare Choice organizations under
12 section 1855(b)(1) and using the identical de-
13 mographic and other adjustments among such
14 categories as are used for such purposes.

15 “(C) REQUIREMENT FOR ADDITIONAL
16 BENEFITS NOT APPLICABLE.—Section
17 1852(e)(1)(A) shall not apply to a high deduct-
18 ible/medisave product.

19 “(e) ADDITIONAL DISCLOSURE.—In any disclosure
20 made pursuant to section 1853(a)(1) for a high deduct-
21 ible/medisave product, the disclosure shall include a com-
22 parison of benefits under such a product with benefits
23 under other Medicare Choice products.

24 “(f) SPECIAL RULES FOR INDIVIDUALS ELECTING
25 HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—

“(1) IN GENERAL.—In the case of an individual who has elected a high deductible/medisave product, notwithstanding the provisions of section 1855—

“(A) the amount of the payment to the Medicare Choice organization offering the high deductible/medisave product shall not exceed the premium for the product, and

“(B) subject to paragraph (2), the difference between the amount of payment that would otherwise be made and the amount of payment to such organization shall be made directly into a Medicare Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

“(2) ESTABLISHMENT AND DESIGNATION OF MEDICARE CHOICE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—

In the case of an individual who has elected coverage under a high deductible/medisave product, no payment shall be made under paragraph (1)(B) on behalf of an individual for a month unless the individual—

“(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare Choice MSA

1 (as defined in section 137(b) of the Internal
2 Revenue Code of 1986), and

3 “(B) if the individual has established more
4 than one Medicare Choice MSA, has designated
5 one of such accounts as the individual’s Medi-
6 care Choice MSA for purposes of this part.

7 Under rules under this section, such an individual
8 may change the designation of such account under
9 subparagraph (B) for purposes of this part.

10 “(3) LUMP SUM DEPOSIT OF MEDICAL SAVINGS
11 ACCOUNT CONTRIBUTION.—In the case of an indi-
12 vidual electing a high deductible/medisave product
13 effective beginning with a month in a year, the
14 amount of the contribution to the Medicare Choice
15 MSA on behalf of the individual for that month and
16 all successive months in the year shall be deposited
17 during that first month. In the case of a termination
18 of such an election as of a month before the end of
19 a year, the Secretary shall provide for a procedure
20 for the recovery of deposits attributable to the re-
21 maining months in the year.

22 “(g) SPECIAL CONTRACT RULES.—

23 “(1) ENROLLMENT REQUIREMENTS WAIVED.—
24 Subsection (b) of section 1858 shall not apply with

respect to a contract that relates only to one or more high deductible/medisave products.

“(2) EFFECTIVE DATE OF CONTRACTS.—In no case shall a contract under section 1858 which provides for coverage under a high deductible/medisave account be effective before January 1997 with respect to such coverage.”.

(b) CONFORMING REFERENCES TO PREVIOUS PART C.—Any reference in law (in effect before the date of the enactment of this Act) to part C of title XVIII of the Social Security Act is deemed a reference to part D of such title (as in effect after such date).

(c) USE OF INTERIM, FINAL REGULATIONS.—In order to carry out the amendment made by subsection (a) in a timely manner, the Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(d) ADVANCE DIRECTIVES.—Section 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) is amended—

(1) in paragraph (1)—

(A) by inserting “1853(g),” after “1833(s),”, and

(B) by inserting “, Medicare Choice organization,” after “provider of services”, and

1 (2) by adding at the end the following new
2 paragraph:

3 “(4) Nothing in this subsection shall be construed to
4 require the provision of information regarding assisted
5 suicide, euthanasia, or mercy killing.”.

6 (e) CONFORMING AMENDMENT.—Section
7 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended
8 by inserting before the semicolon at the end the following:
9 “and in the case of hospitals to accept as payment in full
10 for inpatient hospital services that are covered under this
11 title and are furnished to any individual enrolled under
12 part C with a Medicare Choice organization which does
13 not have a contract establishing payment amounts for
14 services furnished to members of the organization the
15 amounts that would be made as a payment in full under
16 this title if the individuals were not so enrolled”.

17 **SEC. 15003. REPORTS.**

18 (a) ALTERNATIVE PAYMENT APPROACHES.—By not
19 later than ____, the Secretary of Health and Human Serv-
20 ices (in this title referred to as the “Secretary”) shall sub-
21 mit to Congress a report on alternative provider payment
22 approaches under the medicare program, including—

23 (1) combined hospital and physician payments
24 per admission,

1 (2) partial capitation models for subsets of
2 medicare benefits, and

3 (3) risk-sharing arrangements in which the Sec-
4 retary defines the risk corridor and shares in gains
5 and losses.

6 Such report shall include recommendations for implement-
7 ing and testing such approaches and legislation that may
8 be required to implement and test such approaches.

9 (b) COVERAGE OF RETIRED WORKERS.—

10 (1) IN GENERAL.—The Secretary shall work
11 with employers and health benefit plans to develop
12 standards and payment methodologies to allow re-
13 tired workers to continue to participate in employer
14 health plans instead of participating in the medicare
15 program. Such standards shall also cover workers
16 covered under the Federal Employees Health Bene-
17 fits Program under chapter 89 of title 5, United
18 States Code.

19 (2) REPORT.—Not later than 18 months after
20 the date of the enactment of this Act, the Secretary
21 shall submit to Congress a report on the develop-
22 ment of such standards and payment methodologies.
23 The report shall include recommendations relating to
24 such legislation as may be necessary.

1 **SEC. 15004. TRANSITIONAL RULES FOR CURRENT MEDI-**
 2 **CARE HMO PROGRAM.**

3 (a) **TRANSITION FROM CURRENT CONTRACTS.—**

4 (1) **LIMITATION ON NEW CONTRACTS.—**

5 (A) **NO NEW RISK-SHARING CONTRACTS**
 6 **AFTER NEW STANDARDS ESTABLISHED.—**The
 7 Secretary of Health and Human Services (in
 8 this section referred to as the “Secretary”)
 9 shall not enter into any risk-sharing contract
 10 under section 1876 of the Social Security Act
 11 with an eligible organization for any contract
 12 year beginning on or after the date standards
 13 for Medicare Choice organizations and products
 14 are first established under section 1856(a) of
 15 such Act with respect to Medicare Choice orga-
 16 nizations that are insurers or health mainte-
 17 nance organizations unless such a contract had
 18 been in effect under section 1876 of such Act
 19 for the organization for the previous contract
 20 year.

21 (B) **NO NEW COST REIMBURSEMENT CON-**
 22 **TRACTS.—**The Secretary shall not enter into
 23 any cost reimbursement contract under section
 24 1876 of the Social Security Act beginning for
 25 any contract year beginning on or after the
 26 date of the enactment of this Act.

(2) TERMINATION OF CURRENT CONTRACTS.—

(A) RISK-SHARING CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall not extend or continue any risk-sharing contract with an eligible organization under section 1876 of the Social Security Act (for which a contract was entered into consistent with paragraph (1)(A)) for any contract year beginning on or after 1 year after the date standards described in paragraph (1)(A) are established.

(B) COST REIMBURSEMENT CONTRACTS.—

The Secretary shall not extend or continue any reasonable cost reimbursement contract with an eligible organization under section 1876 of the Social Security Act for any contract year beginning on or after January 1, 1998.

(b) CONFORMING PAYMENT RATES.—

(1) RISK-SHARING CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall provide that payment amounts under risk-sharing contracts under section 1876(a) of the Social Security Act for months in a year (beginning with January 1996) shall be computed—

1 (A) with respect to individuals entitled to
2 benefits under both parts A and B of title
3 XVIII of such Act, by substituting payment
4 rates under section 1855(a) of such Act for the
5 payment rates otherwise established under sec-
6 tion 1876(a) of such Act, and

7 (B) with respect to individuals only enti-
8 tled to benefits under part B of such title, by
9 substituting an appropriate proportion of such
10 rates (reflecting the relative proportion of pay-
11 ments under such title attributable to such
12 part) for the payment rates otherwise estab-
13 lished under section 1876(a) of such Act.

14 For purposes of carrying out this paragraph for pay-
15 ment for months in 1996, the Secretary shall com-
16 pute, announce, and apply the payment rates under
17 section 1855(a) of such Act (notwithstanding any
18 deadlines specified in such section) in as timely a
19 manner as possible and may (to the extent nec-
20 essary) provide for retroactive adjustment in pay-
21 ments made not in accordance with such rates.

22 (2) COST CONTRACTS.—Notwithstanding any
23 other provision of law, the Secretary shall provide
24 that payment amounts under cost reimbursement
25 contracts under section 1876(a) of the Social Secu-

1 rity Act shall take into account adjustments in pay-
 2 ment amounts made in parts A and B of title XVIII
 3 of such Act pursuant to the amendments made by
 4 this title.

5 **PART 2—SPECIAL RULES FOR MEDICARE CHOICE**

6 **MEDICAL SAVINGS ACCOUNTS**

7 **SEC. 15011. MEDICARE CHOICE MSA'S.**

8 (a) IN GENERAL.—Part III of subchapter B of chap-
 9 ter 1 of the Internal Revenue Code of 1986 (relating to
 10 amounts specifically excluded from gross income) is
 11 amended by redesignating section 137 as section 138 and
 12 by inserting after section 136 the following new section:

13 **“SEC. 137. MEDICARE CHOICE MSA'S.**

14 “(a) EXCLUSION.—Gross income shall not include
 15 any payment to the Medicare Choice MSA of an individual
 16 by the Secretary of Health and Human Services under
 17 section 1859(f)(1)(B) of the Social Security Act.

18 “(b) MEDICARE CHOICE MSA.—For purposes of this
 19 section—

20 “(1) MEDICARE CHOICE MSA.—The term ‘Medi-
 21 care Choice MSA’ means a trust created or orga-
 22 nized in the United States exclusively for the pur-
 23 pose of paying the qualified medical expenses of the
 24 account holder, but only if the written governing in-

1 strument creating the trust meets the following re-
2 quirements:

3 “(A) Except in the case of a trustee-to-
4 trustee transfer described in subsection (d)(4),
5 no contribution will be accepted unless it is
6 made by the Secretary of Health and Human
7 Services under section 1859(f)(1)(B) of the So-
8 cial Security Act.

9 “(B) The trustee is a bank (as defined in
10 section 408(n)), an insurance company (as de-
11 fined in section 816), or another person who
12 demonstrates to the satisfaction of the Sec-
13 retary that the manner in which such person
14 will administer the trust will be consistent with
15 the requirements of this section.

16 “(C) No part of the trust assets will be in-
17 vested in life insurance contracts.

18 “(D) The assets of the trust will not be
19 commingled with other property except in a
20 common trust fund or common investment
21 fund.

22 “(E) The interest of an individual in the
23 balance in his account is nonforfeitable.

“(F) Trustee-to-trustee transfers described in subsection (d)(4) may be made to and from the trust.

“(2) QUALIFIED MEDICAL EXPENSES.—

“(A) IN GENERAL.—The term ‘qualified medical expenses’ means, with respect to an account holder, amounts paid by such holder—

“(i) for medical care (as defined in section 213(d)) for the account holder, but only to the extent such amounts are not compensated for by insurance or otherwise, or

“(ii) for long-term care insurance for the account holder.

“(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A)(i) shall not apply to any payment for insurance.

“(3) ACCOUNT HOLDER.—The term ‘account holder’ means the individual on whose behalf the Medicare Choice MSA is maintained.

“(4) CERTAIN RULES TO APPLY.—Rules similar to the rules of subsections (g) and (h) of section 408 shall apply for purposes of this section.

“(c) TAX TREATMENT OF ACCOUNTS.—

1 “(1) IN GENERAL.—A Medicare Choice MSA is
2 exempt from taxation under this subtitle unless such
3 MSA has ceased to be a Medicare Choice MSA by
4 reason of paragraph (2). Notwithstanding the pre-
5 ceding sentence, any such MSA is subject to the
6 taxes imposed by section 511 (relating to imposition
7 of tax on unrelated business income of charitable,
8 etc. organizations).

9 “(2) ACCOUNT ASSETS TREATED AS DISTRIB-
10 UTED IN THE CASE OF PROHIBITED TRANSACTIONS
11 OR ACCOUNT PLEDGED AS SECURITY FOR LOAN.—
12 Rules similar to the rules of paragraphs (2) and (4)
13 of section 408(e) shall apply to Medicare Choice
14 MSA’s, and any amount treated as distributed under
15 such rules shall be treated as not used to pay quali-
16 fied medical expenses.

17 “(d) TAX TREATMENT OF DISTRIBUTIONS.—

18 “(1) INCLUSION OF AMOUNTS NOT USED FOR
19 QUALIFIED MEDICAL EXPENSES.—No amount shall
20 be included in the gross income of the account hold-
21 er by reason of a payment or distribution from a
22 Medicare Choice MSA which is used exclusively to
23 pay the qualified medical expenses of the account
24 holder. Any amount paid or distributed from a Medi-

1 care Choice MSA which is not so used shall be in-
2 cluded in the gross income of such holder.

3 “(2) PENALTY FOR DISTRIBUTIONS NOT USED
4 FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM
5 BALANCE NOT MAINTAINED.—

6 “(A) IN GENERAL.—The tax imposed by
7 this chapter for any taxable year in which there
8 is a payment or distribution from a Medicare
9 Choice MSA which is not used exclusively to
10 pay the qualified medical expenses of the ac-
11 count holder shall be increased by 50 percent of
12 the excess (if any) of—

13 “(i) the amount of such payment or
14 distribution, over

15 “(ii) the excess (if any) of—

16 “(I) the fair market value of the
17 assets in the Medicare Choice MSA as
18 of the close of the calendar year pre-
19 ceding the calendar year in which the
20 taxable year begins, over

21 “(II) an amount equal to 60 per-
22 cent of the deductible under the cata-
23 strophic health plan covering the ac-
24 count holder as of January 1 of the

1 calendar year in which the taxable
2 year begins.

3 “(B) EXCEPTIONS.—Subparagraph (A)
4 shall not apply if the payment or distribution is
5 made on or after the date the account holder—

6 “(i) becomes disabled within the
7 meaning of section 72(m)(7), or

8 “(ii) dies.

9 “(C) SPECIAL RULES.—For purposes of
10 subparagraph (A)—

11 “(i) all Medicare Choice MSA’s of the
12 account holder shall be treated as 1 ac-
13 count,

14 “(ii) all payments and distributions
15 not used exclusively to pay the qualified
16 medical expenses of the account holder
17 during any taxable year shall be treated as
18 1 distribution, and

19 “(iii) any distribution of property
20 shall be taken into account at its fair mar-
21 ket value on the date of the distribution.

22 “(3) WITHDRAWAL OF ERRONEOUS CONTRIBU-
23 TIONS.—Paragraphs (1) and (2) shall not apply to
24 any payment or distribution from a Medicare Choice
25 MSA to the Secretary of Health and Human Serv-

ices of an erroneous contribution to such MSA and of the net income attributable to such contribution.

“(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—

Paragraphs (1) and (2) shall not apply to any trustee-to-trustee transfer from a Medicare Choice MSA of an account holder to another Medicare Choice MSA of such account holder.

“(5) COORDINATION WITH MEDICAL EXPENSE

DEDUCTION.—For purposes of section 213, any payment or distribution out of a Medicare Choice MSA for qualified medical expenses shall not be treated as an expense paid for medical care.

“(e) TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—

“(1) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—

“(A) IN GENERAL.—In the case of an account holder’s interest in a Medicare Choice MSA which is payable to (or for the benefit of) such holder’s spouse upon the death of such holder, such Medicare Choice MSA shall be treated as a Medicare Choice MSA of such spouse as of the date of such death.

“(B) SPECIAL RULES IF SPOUSE NOT MEDICARE ELIGIBLE.—If, as of the date of such

1 death, such spouse is not entitled to benefits
2 under title XVIII of the Social Security Act,
3 then after the date of such death—

4 “(i) the Secretary of Health and
5 Human Services may not make any pay-
6 ments to such Medicare Choice MSA, other
7 than payments attributable to periods be-
8 fore such date,

9 “(ii) in applying subsection (b)(2)
10 with respect to such Medicare Choice
11 MSA, references to the account holder
12 shall be treated as including references to
13 any dependent (as defined in section 152)
14 of such spouse and any subsequent spouse
15 of such spouse, and

16 “(iii) in lieu of applying subsection
17 (d)(2), the rules of section 220(f)(2) shall
18 apply.

19 “(2) TREATMENT IF DESIGNATED BENEFICIARY
20 IS NOT SPOUSE.—In the case of an account holder’s
21 interest in a Medicare Choice MSA which is payable
22 to (or for the benefit of) any person other than such
23 holder’s spouse upon the death of such holder—

24 “(A) such account shall cease to be a Med-
25 icare Choice MSA as of the date of death, and

“(B) an amount equal to the fair market value of the assets in such account on such date shall be includible—

“(i) if such person is not the estate of such holder, in such person’s gross income for the taxable year which includes such date, or

“(ii) if such person is the estate of such holder, in such holder’s gross income for last taxable year of such holder.

“(f) REPORTS.—

“(1) IN GENERAL.—The trustee of a Medicare Choice MSA shall make such reports regarding such account to the Secretary and to the account holder with respect to—

“(A) the fair market value of the assets in such Medicare Choice MSA as of the close of each calendar year, and

“(B) contributions, distributions, and other matters,

as the Secretary may require by regulations.

“(2) TIME AND MANNER OF REPORTS.—The reports required by this subsection—

1 “(A) shall be filed at such time and in
2 such manner as the Secretary prescribes in
3 such regulations, and

4 “(B) shall be furnished to the account
5 holder—

6 “(i) not later than January 31 of the
7 calendar year following the calendar year
8 to which such reports relate, and

9 “(ii) in such manner as the Secretary
10 prescribes in such regulations.”

11 (b) EXCLUSION OF MEDICARE CHOICE MSA’S FROM
12 ESTATE TAX.—Part IV of subchapter A of chapter 11 of
13 such Code is amended by adding at the end the following
14 new section:

15 **“SEC. 2057. MEDICARE CHOICE MSA’S.**

16 “For purposes of the tax imposed by section 2001,
17 the value of the taxable estate shall be determined by de-
18 ducting from the value of the gross estate an amount
19 equal to the value of any Medicare Choice MSA (as de-
20 fined in section 137(b)) included in the gross estate.”

21 (c) TAX ON PROHIBITED TRANSACTIONS.—

22 (1) Section 4975 of such Code (relating to tax
23 on prohibited transactions) is amended by adding at
24 the end of subsection (c) the following new para-
25 graph:

“(5) SPECIAL RULE FOR MEDICARE CHOICE MSA’S.—An individual for whose benefit a Medicare Choice MSA (within the meaning of section 137(b)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a Medicare Choice MSA by reason of the application of section 137(c)(2) to such account.”

(2) Paragraph (1) of section 4975(e) of such Code is amended to read as follows:

“(1) PLAN.—For purposes of this section, the term ‘plan’ means—

“(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

“(B) an individual retirement account described in section 408(a),

“(C) an individual retirement annuity described in section 408(b),

“(D) a medical savings account described in section 220(d),

1 “(E) a Medicare Choice MSA described in
2 section 137(b), or

3 “(F) a trust, plan, account, or annuity
4 which, at any time, has been determined by the
5 Secretary to be described in any preceding sub-
6 paragraph of this paragraph.”

7 (d) FAILURE TO PROVIDE REPORTS ON MEDICARE
8 CHOICE MSA’S.—

9 (1) Subsection (a) of section 6693 of such Code
10 (relating to failure to provide reports on individual
11 retirement accounts or annuities) is amended to read
12 as follows:

13 “(a) REPORTS.—

14 “(1) IN GENERAL.—If a person required to file
15 a report under a provision referred to in paragraph
16 (2) fails to file such report at the time and in the
17 manner required by such provision, such person
18 shall pay a penalty of \$50 for each failure unless it
19 is shown that such failure is due to reasonable
20 cause.

21 “(2) PROVISIONS.—The provisions referred to
22 in this paragraph are—

23 “(A) subsections (i) and (l) of section 408
24 (relating to individual retirement plans),

“(B) section 220(h) (relating to medical savings accounts), and

“(C) section 137(f) (relating to Medicare Choice MSA’s).”

(2) The section heading for section 6693 of such Code is amended to read as follows:

“SEC. 6693. FAILURE TO FILE REPORTS ON INDIVIDUAL RETIREMENT PLANS AND CERTAIN OTHER TAX-FAVORED ACCOUNTS; PENALTIES RELATING TO DESIGNATED NONDEDUCTIBLE CONTRIBUTIONS.”

(e) CLERICAL AMENDMENTS.—

(1) The table of sections for part III of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

“Sec. 137. Medicare Choice MSA’s.
“Sec. 138. Cross references to other Acts.”

(2) The table of sections for subchapter B of chapter 68 of such Code is amended by striking the item relating to section 6693 and inserting the following new item:

“Sec. 6693. Failure to file reports on individual retirement plans and certain other tax-favored accounts; penalties relating to designated nondeductible contributions.”

(3) The table of sections for part IV of subchapter A of chapter 11 of such Code is amended by adding at the end the following new item:

“Sec. 2057. Medicare Choice MSA’s.”

1 (f) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 1996.

4 **SEC. 15012. CERTAIN REBATES EXCLUDED FROM GROSS IN-**
5 **COME.**

6 (a) IN GENERAL.—Section 105 of the Internal Reve-
7 nue Code of 1986 (relating to amounts received under ac-
8 cident and health plans) is amended by adding at the end
9 the following new subsection:

10 “(j) CERTAIN REBATES UNDER SOCIAL SECURITY
11 ACT.—Gross income does not include any rebate received
12 under section 1852(e)(1)(A) of the Social Security Act
13 during the taxable year.”

14 (b) EFFECTIVE DATE.—The amendment made by
15 subsection (a) shall apply to amounts received after the
16 date of the enactment of this Act.

17 **PART 3—SPECIAL ANTITRUST RULE FOR**
18 **PROVIDER SERVICE NETWORKS**

19 **SEC. 15021. APPLICATION OF ANTITRUST RULE OF REASON**
20 **TO PROVIDER SERVICE NETWORKS.**

21 (a) RULE OF REASON STANDARD.—In any action
22 under the antitrust laws, or under any State law similar
23 to the antitrust laws—

24 (1) the conduct of a provider service network in
25 negotiating, making, or performing a contract (in-

cluding the establishment and modification of a fee schedule and the development of a panel of physicians), to the extent such contract is for the purpose of providing health care services to individuals under the terms of a Medicare Choice PSO product, and

(2) the conduct of any member of such network for the purpose of providing such health care services under such contract to such extent,

shall not be deemed illegal per se. Such conduct shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including the effects on competition in properly defined markets.

(b) DEFINITIONS.—For purposes of subsection (a):

(1) ANTITRUST LAWS.—The term “antitrust laws” has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(2) HEALTH CARE PROVIDER.—The term “health care provider” means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State

1 to engage in the delivery of such services in the
2 State.

3 (3) HEALTH CARE SERVICE.—The term “health
4 care service” means any service for which payment
5 may be made under a Medicare Choice PSO product
6 including services related to the delivery or adminis-
7 tration of such service.

8 (4) MEDICARE CHOICE PROGRAM.—The term
9 “Medicare Choice program” means the program
10 under part C of title XVIII of the Social Security
11 Act.

12 (5) MEDICARE CHOICE PSO PRODUCT.—The
13 term “Medicare Choice PSO product” means a Med-
14 icare Choice product offered by a provider-sponsored
15 organization under part C of title XVIII of the So-
16 cial Security Act.

17 (6) PROVIDER SERVICE NETWORK.—The term
18 “provider service network” means an organization
19 that—

20 (A) is organized by, operated by, and com-
21 posed of members who are health care providers
22 and for purposes that include providing health
23 care services,

1 (B) is funded in part by capital contribu-
2 tions made by the members of such organiza-
3 tion,

4 (C) with respect to each contract made by
5 such organization for the purpose of providing
6 a type of health care service to individuals
7 under the terms of a Medicare Choice PSO
8 product—

9 (i) requires all members of such orga-
10 nization who engage in providing such type
11 of health care service to agree to provide
12 health care services of such type under
13 such contract,

14 (ii) receives the compensation paid for
15 the health care services of such type pro-
16 vided under such contract by such mem-
17 bers, and

18 (iii) provides for the distribution of
19 such compensation,

20 (D) has established, consistent with the re-
21 quirements of the Medicare Choice program for
22 provider-sponsored organizations, a program to
23 review, pursuant to written guidelines, the qual-
24 ity, efficiency, and appropriateness of treatment
25 methods and setting of services for all health

1 care providers and all patients participating in
 2 such product, along with internal procedures to
 3 correct identified deficiencies relating to such
 4 methods and such services,

5 (E) has established, consistent with the re-
 6 quirements of the Medicare Choice program for
 7 provider-sponsored organizations, a program to
 8 monitor and control utilization of health care
 9 services provided under such product, for the
 10 purpose of improving efficient, appropriate care
 11 and eliminating the provision of unnecessary
 12 health care services,

13 (F) has established a management pro-
 14 gram to coordinate the delivery of health care
 15 services for all health care providers and all pa-
 16 tients participating in such product, for the
 17 purpose of achieving efficiencies and enhancing
 18 the quality of health care services provided, and

19 (G) has established, consistent with the re-
 20 quirements of the Medicare Choice program for
 21 provider-sponsored organizations, a grievance
 22 and appeal process for such organization de-
 23 signed to review and promptly resolve bene-
 24 ficiary or patient grievances and complaints.

Such term may include a provider-sponsored organization.

(7) PROVIDER-SPONSORED ORGANIZATION.—

The term “provider-sponsored organization” means a Medicare Choice organization under the Medicare Choice program that is a provider-sponsored organization (as defined in section ____ of the Social Security Act).

(8) STATE.—The term “State” has the mean-

ing given it in section 4G(2) of the Clayton Act (15 U.S.C. 15g(2)).

(c) ISSUANCE OF GUIDELINES.—Not later than 120

days after the date of the enactment of this Act, the Attorney General and the Federal Trade Commission shall issue jointly guidelines specifying the enforcement policies and analytical principles that will be applied by the Department of Justice and the Commission with respect to the operation of subsection (a).

PART 4—COMMISSIONS

SEC. 15031. MEDICARE PAYMENT REVIEW COMMISSION.

(a) IN GENERAL.—Title XVIII, as amended by sec-

tion 8001(a), is amended by inserting after section 1805 the following new section:

1 “MEDICARE PAYMENT REVIEW COMMISSION

2 “SEC. 1806. (a) ESTABLISHMENT.—There is hereby
3 established the Medicare Payment Review Commission (in
4 this section referred to as the ‘Commission’).

5 “(b) DUTIES.—

6 “(1) GENERAL DUTIES AND REPORTS.—The
7 Commission shall review, and make recommenda-
8 tions to Congress concerning, payment policies under
9 this title. By not later than June 1 of each year, the
10 Commission shall submit a report to Congress con-
11 taining an examination of issues affecting the medi-
12 care program, including the implications of changes
13 in health care delivery in the United States and in
14 the market for health care services on the medicare
15 program. The Commission may submit to Congress
16 from time to time such other reports as the Commis-
17 sion deems appropriate. The Secretary shall respond
18 to recommendations of the Commission in notices of
19 rulemaking proceedings under this title.

20 “(2) SPECIFIC DUTIES RELATING TO MEDICARE
21 CHOICE PROGRAM.—Specifically, the Commission
22 shall review, with respect to the Medicare Choice
23 program under part C—

24 “(A) the appropriateness of the methodol-
25 ogy for making payment to plans under such

1 program, including the making of differential
2 payments and the distribution of differential
3 updates among different payment areas,

4 “(B) the appropriateness of the mecha-
5 nisms used to adjust payments for risk and the
6 need to adjust such mechanisms to take into ac-
7 count health status of beneficiaries,

8 “(C) the implications of risk selection both
9 among Medicare Choice organizations and be-
10 tween the Medicare Choice option and the non-
11 Medicare Choice option,

12 “(D) in relation to payment under part C,
13 the development and implementation of mecha-
14 nisms to assure the quality of care for those en-
15 rolled with Medicare Choice organizations,

16 “(F) the impact of the Medicare Choice
17 program on access to care for medicare bene-
18 ficiaries, and

19 “(G) other major issues in implementation
20 and further development of the Medicare Choice
21 program.

22 “(3) SPECIFIC DUTIES RELATING TO THE FEE-
23 FOR-SERVICE SYSTEM.—Specifically, the Commission
24 shall review payment policies under parts A and B,
25 including—

1 “(A) the factors affecting expenditures for
2 services in different sectors, including the proc-
3 ess for updating hospital, physician, and other
4 fees,

5 “(B) payment methodologies; and

6 “(C) the impact of payment policies on ac-
7 cess and quality of care for medicare bene-
8 ficiaries.

9 “(4) SPECIFIC DUTIES RELATING TO INTER-
10 ACTION OF PAYMENT POLICIES WITH HEALTH CARE
11 DELIVERY GENERALLY.—Specifically the Commis-
12 sion shall review the effect of payment policies under
13 this title on the delivery of health care services
14 under this title and assess the implications of
15 changes in the health services market on the medi-
16 care program.

17 “(c) MEMBERSHIP.—

18 “(1) NUMBER AND APPOINTMENT.—The Com-
19 mission shall be composed of 15 members appointed
20 by the Comptroller General.

21 “(2) QUALIFICATIONS.—The membership of the
22 Commission shall include individuals with national
23 recognition for their expertise in health finance and
24 economics, actuarial science, health facility manage-
25 ment, health plans and integrated delivery systems,

reimbursement of health facilities, physicians, and other providers of services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives, including physicians and other health professionals, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

“(3) CONSIDERATIONS IN INITIAL APPOINTMENT.—To the extent possible, in first appointing members to the Commission the Comptroller General shall consider appointing individuals who (as of the date of the enactment of this section) were serving on the Prospective Payment Assessment Commission or the Physician Payment Review Commission.

“(4) TERMS.—

“(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall des-

1 ignite staggered terms for the members first
2 appointed.

3 “(B) VACANCIES.—Any member appointed
4 to fill a vacancy occurring before the expiration
5 of the term for which the member’s predecessor
6 was appointed shall be appointed only for the
7 remainder of that term. A member may serve
8 after the expiration of that member’s term until
9 a successor has taken office. A vacancy in the
10 Commission shall be filled in the manner in
11 which the original appointment was made.

12 “(5) COMPENSATION.—While serving on the
13 business of the Commission (including traveltime), a
14 member of the Commission shall be entitled to com-
15 pensation at the per diem equivalent of the rate pro-
16 vided for level IV of the Executive Schedule under
17 section 5315 of title 5, United States Code; and
18 while so serving away from home and member’s reg-
19 ular place of business, a member may be allowed
20 travel expenses, as authorized by the Chairman of
21 the Commission. Physicians serving as personnel of
22 the Commission may be provided a physician com-
23 parability allowance by the Commission in the same
24 manner as Government physicians may be provided
25 such an allowance by an agency under section 5948

of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

“(6) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment.

“(7) MEETINGS.—The Commission shall meet at the call of the Chairman.

“(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

“(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

1 “(2) seek such assistance and support as may
2 be required in the performance of its duties from ap-
3 propriate Federal departments and agencies;

4 “(3) enter into contracts or make other ar-
5 rangements, as may be necessary for the conduct of
6 the work of the Commission (without regard to sec-
7 tion 3709 of the Revised Statutes (41 U.S.C. 5));

8 “(4) make advance, progress, and other pay-
9 ments which relate to the work of the Commission;

10 “(5) provide transportation and subsistence for
11 persons serving without compensation; and

12 “(6) prescribe such rules and regulations as it
13 deems necessary with respect to the internal organi-
14 zation and operation of the Commission.

15 “(e) POWERS.—

16 “(1) OBTAINING OFFICIAL DATA.—The Com-
17 mission may secure directly from any department or
18 agency of the United States information necessary
19 to enable it to carry out this section. Upon request
20 of the Chairman, the head of that department or
21 agency shall furnish that information to the Com-
22 mission on an agreed upon schedule.

23 “(2) DATA COLLECTION.—In order to carry out
24 its functions, the Commission shall collect and as-
25 sess information to—

“(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

“(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

“(C) adopt procedures allowing any interested party to submit information for the Commission’s use in making reports and recommendations.

“(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

“(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the General Accounting Office.

“(f) AUTHORIZATION OF APPROPRIATIONS.—

“(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts ap-

1 appropriated for the Commission shall be separate
2 from amounts appropriated for the Comptroller Gen-
3 eral.

4 “(2) AUTHORIZATION.—There are authorized to
5 be appropriated such sums as may be necessary to
6 carry out the provisions of this section. 60 percent
7 of such appropriation shall be payable from the Fed-
8 eral Hospital Insurance Trust Fund, and 40 percent
9 of such appropriation shall be payable from the Fed-
10 eral Supplementary Medical Insurance Trust
11 Fund.”.

12 (b) ABOLITION OF PROPAC AND PPRC.—

13 (1) PROPAC.—

14 (A) IN GENERAL.—Section 1886(e) (42
15 U.S.C. 1395ww(e)) is amended—

16 (i) by striking paragraphs (2) and (6);

17 and

18 (ii) in paragraph (3), by striking “(A)
19 The Commission” and all that follows
20 through “(B)”.

21 (B) CONFORMING AMENDMENT.—Section
22 1862 (42 U.S.C. 1395y) is amended by striking
23 “Prospective Payment Assessment Commis-
24 sion” each place it appears in subsection

(a)(1)(D) and subsection (i) and inserting
“Medicare Payment Review Commission”.

(2) PPRC.—

(A) IN GENERAL.—Title XVIII is amended
by striking section 1845 (42 U.S.C. 1395w–1).

(B) CONFORMING AMENDMENTS.—

(i) Section 1834(b)(2) (42 U.S.C.
1395m(b)(2)) is amended by striking
“Physician Payment Review Commission”
and inserting “Medicare Payment Review
Commission”.

(ii) Section 1842(b) (42 U.S.C.
1395u(b)) is amended by striking “Physi-
cian Payment Review Commission” each
place it appears in paragraphs (2)(C),
(9)(D), and (14)(C)(i) and inserting “Med-
icare Payment Review Commission”.

(iii) Section 1848 (42 U.S.C.
1395w@4) is amended by striking “Physi-
cian Payment Review Commission” and in-
serting “Medicare Payment Review Com-
mission” each place it appears in para-
graph (2)(A)(ii), (2)(B)(iii), and (5) of
subsection (c), subsection (d)(2)(F), para-
graphs (1)(B), (3), and (4)(A) of subsection

1 (f), and paragraphs (6)(C) and (7)(C) of
2 subsection (g).

3 (c) EFFECTIVE DATE; TRANSITION.—

4 (1) IN GENERAL.—The Comptroller General
5 shall first provide for appointment of members to
6 the Medicare Payment Review Commission (in this
7 subsection referred to as “MPRC”) by not later
8 than March 31, 1996.

9 (2) TRANSITION.—Effective on a date (not later
10 than 30 days after the date a majority of members
11 of the MPRC have first been appointed, the Pro-
12 spective Payment Assessment Commission (in this
13 subsection referred to as “ProPAC”) and the Physi-
14 cian Payment Review Commission (in this subsection
15 referred to as “PPRC”), and amendments made by
16 subsection (b), are terminated. The Comptroller
17 General, to the maximum extent feasible, shall pro-
18 vide for the transfer to the MPRC of assets and
19 staff of ProPAC and PPRC, without any loss of
20 benefits or seniority by virtue of such transfers.
21 Fund balances available to the ProPAC or PPRC
22 for any period shall be available to the MPRC for
23 such period for like purposes.

24 (3) CONTINUING RESPONSIBILITY FOR RE-
25 PORTS.—The MPRC shall be responsible for the

preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MPRC) by the ProPAC and PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MPRC, to refer to the MPRC.

SEC. 15032. COMMISSION ON THE EFFECT OF THE BABY BOOM GENERATION ON THE MEDICARE PROGRAM.

(a) **ESTABLISHMENT.**—There is established a commission to be known as the Commission on the Effect of the Baby Boom Generation on the Medicare Program (in this section referred to as the “Commission”).

(b) **DUTIES.**—

(1) **IN GENERAL.**—The Commission shall—

(A) examine the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals which will occur beginning approximately during 2010 and lasting for approximately 25 years, and

(B) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period

1 during which such individuals are eligible for
2 medicare.

3 (2) CONSIDERATIONS IN MAKING REC-
4 OMMENDATIONS.—In making its recommendations,
5 the Commission shall consider the following:

6 (A) The amount and sources of Federal
7 funds to finance the medicare program, includ-
8 ing the potential use of innovative financing
9 methods.

10 (B) The most efficient and effective man-
11 ner of administering the program, including the
12 appropriateness of continuing the application of
13 the failsafe budget mechanism under section
14 1895 of the Social Security Act for fiscal years
15 after fiscal year 2002 and the appropriate long-
16 term growth rates for contributions electing
17 coverage under Medicare Choice under part C
18 of title XVIII of such Act.

19 (C) Methods used by other nations to re-
20 spond to comparable demographic patterns in
21 eligibility for health care benefits for elderly
22 and disabled individuals.

23 (D) Modifying age-based eligibility to cor-
24 respond to changes in age-based eligibility
25 under the OASDI program.

(E) Trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices.

(c) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

(A) The President shall appoint 3 members.

(B) The Majority Leader of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members, of whom not more than 4 may be of the same political party.

(C) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members, of whom not more than 4 may be of the same political party.

(2) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a Chairman and Vice Chairman from among its members.

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and

1 shall not affect the power of the remaining members
2 to execute the duties of the Commission.

3 (4) QUORUM.—A quorum shall consist of 8
4 members of the Commission, except that 4 members
5 may conduct a hearing under subsection (e).

6 (5) MEETINGS.—The Commission shall meet at
7 the call of its Chairman or a majority of its mem-
8 bers.

9 (6) COMPENSATION AND REIMBURSEMENT OF
10 EXPENSES.—Members of the Commission are not
11 entitled to receive compensation for service on the
12 Commission. Members may be reimbursed for travel,
13 subsistence, and other necessary expenses incurred
14 in carrying out the duties of the Commission.

15 (d) STAFF AND CONSULTANTS.—

16 (1) STAFF.—The Commission may appoint and
17 determine the compensation of such staff as may be
18 necessary to carry out the duties of the Commission.
19 Such appointments and compensation may be made
20 without regard to the provisions of title 5, United
21 States Code, that govern appointments in the com-
22 petitive services, and the provisions of chapter 51
23 and subchapter III of chapter 53 of such title that
24 relate to classifications and the General Schedule
25 pay rates.

(2) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

(e) POWERS.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(A) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the of-

1 fice of the Director of such additional staff as
2 may be necessary for the Director to comply
3 with requests by the Commission under sub-
4 paragraph (A).

5 (4) DETAIL OF FEDERAL EMPLOYEES.—Upon
6 the request of the Commission, the head of any Fed-
7 eral agency is authorized to detail, without reim-
8 bursement, any of the personnel of such agency to
9 the Commission to assist the Commission in carry-
10 ing out its duties. Any such detail shall not interrupt
11 or otherwise affect the civil service status or privi-
12 leges of the Federal employee.

13 (5) TECHNICAL ASSISTANCE.—Upon the re-
14 quest of the Commission, the head of a Federal
15 agency shall provide such technical assistance to the
16 Commission as the Commission determines to be
17 necessary to carry out its duties.

18 (6) USE OF MAILS.—The Commission may use
19 the United States mails in the same manner and
20 under the same conditions as Federal agencies and
21 shall, for purposes of the frank, be considered a
22 commission of Congress as described in section 3215
23 of title 39, United States Code.

24 (7) OBTAINING INFORMATION.—The Commis-
25 sion may secure directly from any Federal agency

1 information necessary to enable it to carry out its
2 duties, if the information may be disclosed under
3 section 552 of title 5, United States Code. Upon re-
4 quest of the Chairman of the Commission, the head
5 of such agency shall furnish such information to the
6 Commission.

7 (8) ADMINISTRATIVE SUPPORT SERVICES.—

8 Upon the request of the Commission, the Adminis-
9 trator of General Services shall provide to the Com-
10 mission on a reimbursable basis such administrative
11 support services as the Commission may request.

12 (9) ACCEPTANCE OF DONATIONS.—The Com-

13 mission may accept, use, and dispose of gifts or do-
14 nations of services or property.

15 (10) PRINTING.—For purposes of costs relating

16 to printing and binding, including the cost of per-
17 sonnel detailed from the Government Printing Of-
18 fice, the Commission shall be deemed to be a com-
19 mittee of the Congress.

20 (f) REPORT.—Not later than May 1, 1997, the Com-

21 mission shall submit to Congress a report containing its
22 findings and recommendations regarding how to protect
23 and preserve the medicare program in a financially solvent
24 manner until 2030 (or, if later, throughout the period of
25 projected solvency of the Federal Old-Age and Survivors

1 Insurance Trust Fund). The report shall include detailed
2 recommendations for appropriate legislative initiatives re-
3 specting how to accomplish this objective.

4 (g) TERMINATION.—The Commission shall terminate
5 60 days after the date of submission of the report required
6 in subsection (f).

7 (h) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated \$1,500,000 to carry out
9 this section. Amounts appropriated to carry out this sec-
10 tion shall remain available until expended.

11 **PART 5—PREEMPTION OF STATE ANTI-MANAGED**
12 **CARE LAWS**

13 **SEC. 15041. PREEMPTION OF STATE LAW RESTRICTIONS ON**
14 **MANAGED CARE ARRANGEMENTS.**

15 (a) LIMITATION ON RESTRICTIONS ON NETWORK
16 PLANS.—Effective as of January 1, 1997—

17 (1) a State may not prohibit or limit a carrier
18 or group health plan providing health coverage from
19 including incentives for enrollees to use the services
20 of participating providers;

21 (2) a State may not prohibit or limit such a
22 carrier or plan from limiting coverage of services to
23 those provided by a participating provider, except as
24 provided in section 1013;

(3) a State may not prohibit or limit the negotiation of rates and forms of payments for providers by such a carrier or plan with respect to health coverage;

(4) a State may not prohibit or limit such a carrier or plan from limiting the number of participating providers;

(5) a State may not prohibit or limit such a carrier or plan from requiring that services be provided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers or, except for services of a physician who specializes in obstetrics and gynecology, from requiring enrollees to obtain referral in order to have coverage for treatment by a specialist or health institution; and

(6) a State may not prohibit or limit the corporate practice of medicine.

(b) DEFINITIONS.—In this section:

(1) MANAGED CARE COVERAGE.—The term “managed care coverage” means health coverage to the extent the coverage is provided through a managed care arrangement (as defined in paragraph (3)) that meets the applicable requirements of such section.

1 (2) PARTICIPATING PROVIDER.—The term
2 “participating provider” means an entity or individ-
3 ual which provides, sells, or leases health care serv-
4 ices as part of a provider network (as defined in
5 paragraph (4)).

6 (3) MANAGED CARE ARRANGEMENT.—The term
7 “managed care arrangement” means, with respect to
8 a group health plan or under health insurance cov-
9 erage, an arrangement under such plan or coverage
10 under which providers agree to provide items and
11 services covered under the arrangement to individ-
12 uals covered under the plan or who have such cov-
13 erage.

14 (4) PROVIDER NETWORK.—The term “provider
15 network” means, with respect to a group health plan
16 or health insurance coverage, providers who have en-
17 tered into an agreement described in paragraph (3).

18 **SEC. 15042. PREEMPTION OF STATE LAWS RESTRICTING**
19 **UTILIZATION REVIEW PROGRAMS.**

20 (a) IN GENERAL.—Effective January 1, 1997, no
21 State law or regulation shall prohibit or regulate activities
22 under a utilization review program (as defined in sub-
23 section (b)).

24 (b) UTILIZATION REVIEW PROGRAM DEFINED.—In
25 this section, the term “utilization review program” means

1 a system of reviewing the medical necessity and appro-
 2 priateness of patient services (which may include inpatient
 3 and outpatient services) using specified guidelines. Such
 4 a system may include preadmission certification, the appli-
 5 cation of practice guidelines, continued stay review, dis-
 6 charge planning, preauthorization of ambulatory proce-
 7 dures, and retrospective review.

8 (c) EXEMPTION OF LAWS PREVENTING DENIAL OF
 9 LIFESAVING MEDICAL TREATMENT PENDING TRANSFER
 10 TO ANOTHER HEALTH CARE PROVIDER.—Nothing in this
 11 subtitle shall be construed to invalidate any State law that
 12 has the effect of preventing involuntary denial of life-pre-
 13 serving medical treatment when such denial would cause
 14 the involuntary death of the patient pending transfer of
 15 the patient to a health care provider willing to provide
 16 such treatment.

17 **Subtitle B—Provisions Relating to** 18 **Regulatory Relief**

19 **PART 1—PROVISIONS RELATING TO PHYSICIAN** 20 **FINANCIAL RELATIONSHIPS**

21 **SEC. 15101. REPEAL OF PROHIBITIONS BASED ON COM-** 22 **PENSATION ARRANGEMENTS.**

23 (a) IN GENERAL.—Section 1877(a)(2) (42 U.S.C.
 24 1395nn(a)(2)) is amended by striking “is—” and all that
 25 follows through “equity,” and inserting the following: “is

1 (except as provided in subsection (c)) an ownership or in-
2 vestment interest in the entity through equity,”.

3 (b) CONFORMING AMENDMENTS.—Section 1877 (42
4 U.S.C. 1395nn) is amended as follows:

5 (1) In subsection (b)—

6 (A) in the heading, by striking “TO BOTH
7 OWNERSHIP AND COMPENSATION ARRANGE-
8 MENT PROVISIONS” and inserting “WHERE FI-
9 NANCIAL RELATIONSHIP EXISTS”; and

10 (B) by redesignating paragraph (4) as
11 paragraph (7).

12 (2) In subsection (c)—

13 (A) by amending the heading to read as
14 follows: “EXCEPTION FOR OWNERSHIP OR IN-
15 VESTMENT INTEREST IN PUBLICLY TRADED
16 SECURITIES AND MUTUAL FUNDS”; and

17 (B) in the matter preceding paragraph (1),
18 by striking “subsection (a)(2)(A)” and inserting
19 “subsection (a)(2)”.

20 (3) In subsection (d)—

21 (A) by striking the matter preceding para-
22 graph (1);

23 (B) in paragraph (3), by striking “para-
24 graph (1)” and inserting “paragraph (4)”; and

(C) by redesignating paragraphs (1), (2), and (3) as paragraphs (4), (5), and (6), and by transferring and inserting such paragraphs after paragraph (3) of subsection (b).

(4) By striking subsection (e).

(5) In subsection (f)(2), as amended by section 152(a) of the Social Security Act Amendments of 1994—

(A) in the matter preceding paragraph (1), by striking “ownership, investment, and compensation” and inserting “ownership and investment”;

(B) in paragraph (2), by striking “subsection (a)(2)(A)” and all that follows through “subsection (a)(2)(B)),” and inserting “subsection (a)(2),”; and

(C) in paragraph (2), by striking “or who have such a compensation relationship with the entity”.

(6) In subsection (h)—

(A) by striking paragraphs (1), (2), and (3);

(B) in paragraph (4)(A), by striking clauses (iv) and (vi);

1 (C) in paragraph (4)(B), by striking
 2 “RULES.—” and all that follows through “(ii)
 3 FACULTY” and inserting “RULES FOR FAC-
 4 ULTY; and

5 (D) by adding at the end of paragraph (4)
 6 the following new subparagraph:

7 “(C) MEMBER OF A GROUP.—A physician
 8 is a ‘member’ of a group if the physician is an
 9 owner or a bona fide employee, or both, of the
 10 group.”.

11 **SEC. 15102. REVISION OF DESIGNATED HEALTH SERVICES**
 12 **SUBJECT TO PROHIBITION.**

13 (a) IN GENERAL.—Section 1877(h)(6) (42 U.S.C.
 14 1395nn(h)(6)) is amended by striking subparagraphs (B)
 15 through (K) and inserting the following:

16 “(B) Items and services furnished by a
 17 community pharmacy (as defined in paragraph
 18 (1)).

19 “(C) Magnetic resonance imaging and
 20 computerized tomography services.

21 “(D) Outpatient physical therapy serv-
 22 ices.”.

23 (b) COMMUNITY PHARMACY DEFINED.—Section
 24 1877(h) (42 U.S.C. 1395nn(h)), as amended by section

1 15101(b)(6), is amended by inserting before paragraph
2 (4) the following new paragraph:

3 “(1) COMMUNITY PHARMACY.—The term ‘com-
4 munity pharmacy’ means any entity licensed or cer-
5 tified to dispense prescription drugs by the State in
6 which the entity is located (including an entity which
7 dispenses such drugs by mail order).”.

8 (c) CONFORMING AMENDMENTS.—

9 (1) Section 1877(b)(2) (42 U.S.C.
10 1395nn(b)(2)) is amended in the matter preceding
11 subparagraph (A) by striking “services” and all that
12 follows through “supplies)—” and inserting “serv-
13 ices—”.

14 (2) Section 1877(h)(5)(C) (42 U.S.C.
15 1395nn(h)(5)(C)) is amended—

16 (A) by striking “, a request by a radiolo-
17 gist for diagnostic radiology services, and a re-
18 quest by a radiation oncologist for radiation
19 therapy,” and inserting “and a request by a ra-
20 diologist for magnetic resonance imaging or for
21 computerized tomography”, and

22 (B) by striking “radiologist, or radiation
23 oncologist” and inserting “or radiologist”.

1 **SEC. 15103. DELAY IN IMPLEMENTATION UNTIL PROMUL-**
 2 **GATION OF REGULATIONS.**

3 (a) IN GENERAL.—Section 13562(b) of OBRA–1993
 4 (42 U.S.C. 1395nn note) is amended—

5 (1) in paragraph (1), by striking “paragraph
 6 (2)” and inserting “paragraphs (2) and (3)”; and
 7 (2) by adding at the end the following new
 8 paragraph:

9 “(3) PROMULGATION OF REGULATIONS.—Not-
 10 withstanding paragraphs (1) and (2), the amend-
 11 ments made by this section shall not apply to any
 12 referrals made before the effective date of final regu-
 13 lations promulgated by the Secretary of Health and
 14 Human Services to carry out such amendments.”.

15 (b) EFFECTIVE DATE.—The amendments made by
 16 subsection (a) shall take effect as if included in the enact-
 17 ment of OBRA–1993.

18 **SEC. 15104. EXCEPTIONS TO PROHIBITION.**

19 (a) REVISIONS TO EXCEPTION FOR IN-OFFICE AN-
 20 CILLARY SERVICES.—

21 (1) REPEAL OF SITE-OF-SERVICE REQUIRE-
 22 MENT.—Section 1877 (42 U.S.C. 1395nn) is amend-
 23 ed—

24 (A) by amending subparagraph (A) of sub-
 25 section (b)(2) to read as follows:

“(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are under the general supervision of the physician or of another physician in the group practice, and”, and

(B) by adding at the end of subsection (h) the following new paragraph:

“(7) GENERAL SUPERVISION.—An individual is considered to be under the ‘general supervision’ of a physician if the physician (or group practice of which the physician is a member) is legally responsible for the services performed by the individual and for ensuring that the individual meets licensure and certification requirements, if any, applicable under other provisions of law, regardless of whether or not the physician is physically present when the individual furnishes an item or service.”.

(2) CLARIFICATION OF TREATMENT OF PHYSICIAN OWNERS OF GROUP PRACTICE.—Section 1877(b)(2)(B) (42 U.S.C. 1395nn(b)(2)(B)) is amended by striking “physician or such group practice” and inserting “physician, such group practice, or the physician owners of such group practice”.

1 (3) CONFORMING AMENDMENT.—Section
2 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended by
3 amending the heading to read as follows: “ANCIL-
4 LARY SERVICES FURNISHED PERSONALLY OR
5 THROUGH GROUP PRACTICE.—”.

6 (b) CLARIFICATION OF EXCEPTION FOR SERVICES
7 FURNISHED IN A RURAL AREA.—Paragraph (5) of section
8 1877(b) (42 U.S.C. 1395nn(b)), as transferred by section
9 15101(b)(3)(C), is amended by striking “substantially all”
10 and inserting “not less than 75 percent”.

11 (c) REVISION OF EXCEPTION FOR CERTAIN MAN-
12 AGED CARE ARRANGEMENTS.—Section 1877(b)(3) (42
13 U.S.C. 1395nn(b)(3)) is amended—

14 (1) in the heading by inserting “MANAGED
15 CARE ARRANGEMENTS” after “PREPAID PLANS”;

16 (2) in the matter preceding subparagraph (A),
17 by striking “organization—” and inserting “organi-
18 zation, directly or through contractual arrangements
19 with other entities, to individuals enrolled with the
20 organization—”;

21 (3) in subparagraph (A), by inserting “or part
22 C” after “section 1876”;

23 (4) by striking “or” at the end of subparagraph
24 (C);

1 (5) by striking the period at the end of sub-
2 paragraph (D) and inserting a comma; and

3 (6) by adding at the end the following new sub-
4 paragraphs:

5 “(E) with a contract with a State to pro-
6 vide services under the State plan under title
7 XIX (in accordance with section 1903(m)) or a
8 State MediGrant plan under title XXI; or

9 “(F) which—

10 “(i) provides health care items or
11 services directly or through one or more
12 subsidiary entities or arranges for the pro-
13 vision of health care items or services sub-
14 stantially through the services of health
15 care providers under contract with the or-
16 ganization, and

17 “(ii)(I) assumes financial risk for the
18 provision of health services through mecha-
19 nisms (such as capitation, risk pools, with-
20 holds, and per diem payments) or offers its
21 network of contract health providers to an
22 entity (including self-insured employers
23 and indemnity plans) which assumes finan-
24 cial risk for the provision of such health
25 services, or

1 “(II) has in effect a written agree-
2 ment with the provider of services under
3 which the provider is at significant finan-
4 cial risk (whether through a withhold, capi-
5 tation, incentive pool, per diem payments,
6 or similar risk sharing arrangement) for
7 the cost or utilization of services that the
8 provider is obligated to provide.”.

9 (d) NEW EXCEPTION FOR SHARED FACILITY SERV-
10 ICES.—

11 (1) IN GENERAL.—Section 1877(b) (42 U.S.C.
12 1395nn(b)), as amended by section 15101(b)(3)(C),
13 is amended—

14 (A) by redesignating paragraphs (4)
15 through (7) as paragraphs (5) through (8); and
16 (B) by inserting after paragraph (3) the
17 following new paragraph:

18 “(4) SHARED FACILITY SERVICES.—In the case
19 of a designated health service consisting of a shared
20 facility service of a shared facility—

21 “(A) that is furnished—

22 “(i) personally by the referring physi-
23 cian who is a shared facility physician or
24 personally by an individual directly em-

1 employed or under the general supervision of
2 such a physician,

3 “(ii) by a shared facility in a building
4 in which the referring physician furnishes
5 substantially all of the services of the phy-
6 sician that are unrelated to the furnishing
7 of shared facility services, and

8 “(iii) to a patient of a shared facility
9 physician; and

10 “(B) that is billed by the referring physi-
11 cian or a group practice of which the physician
12 is a member.”.

13 (2) DEFINITIONS.—Section 1877(h) (42 U.S.C.
14 1395nn(h)), as amended by section 15101(b)(6) and
15 section 15102(b), is amended by inserting after
16 paragraph (1) the following new paragraph:

17 “(2) SHARED FACILITY RELATED DEFINI-
18 TIONS.—

19 “(A) SHARED FACILITY SERVICE.—The
20 term ‘shared facility service’ means, with re-
21 spect to a shared facility, a designated health
22 service furnished by the facility to patients of
23 shared facility physicians.

24 “(B) SHARED FACILITY.—The term
25 ‘shared facility’ means an entity that furnishes

1 shared facility services under a shared facility
2 arrangement.

3 “(C) SHARED FACILITY PHYSICIAN.—The
4 term ‘shared facility physician’ means, with re-
5 spect to a shared facility, a physician (or a
6 group practice of which the physician is a mem-
7 ber) who has a financial relationship under a
8 shared facility arrangement with the facility.

9 “(D) SHARED FACILITY ARRANGEMENT.—
10 The term ‘shared facility arrangement’ means,
11 with respect to the provision of shared facility
12 services in a building, a financial arrange-
13 ment—

14 “(i) which is only between physicians
15 who are providing services (unrelated to
16 shared facility services) in the same build-
17 ing,

18 “(ii) in which the overhead expenses
19 of the facility are shared, in accordance
20 with methods previously determined by the
21 physicians in the arrangement, among the
22 physicians in the arrangement, and

23 “(iii) which, in the case of a corpora-
24 tion, is wholly owned and controlled by
25 shared facility physicians.”.

1 (e) NEW EXCEPTION FOR SERVICES FURNISHED IN
2 COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—
3 Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by
4 section 15101(b)(3)(C) and subsection (d)(1), is amend-
5 ed—

6 (1) by redesignating paragraphs (5) through
7 (8) as paragraphs (6) through (9); and

8 (2) by inserting after paragraph (4) the follow-
9 ing new paragraph:

10 “(5) NO ALTERNATIVE PROVIDERS IN AREA.—

11 In the case of a designated health service furnished
12 in any area with respect to which the Secretary de-
13 termines that individuals residing in the area do not
14 have reasonable access to such a designated health
15 service for which subsection (a)(1) does not apply.”.

16 (f) NEW EXCEPTION FOR SERVICES FURNISHED IN
17 AMBULATORY SURGICAL CENTERS.—Section 1877(b) (42
18 U.S.C. 1395nn(b)), as amended by section
19 15101(b)(3)(C), subsection (d)(1), and subsection (e)(1),
20 is amended—

21 (1) by redesignating paragraphs (6) through
22 (9) as paragraphs (7) through (10); and

23 (2) by inserting after paragraph (5) the follow-
24 ing new paragraph:

1 “(6) SERVICES FURNISHED IN AMBULATORY
2 SURGICAL CENTERS.—In the case of a designated
3 health service furnished in an ambulatory surgical
4 center described in section 1832(a)(2)(F)(i).”.

5 (g) NEW EXCEPTION FOR SERVICES FURNISHED IN
6 RENAL DIALYSIS FACILITIES.—Section 1877(b) (42
7 U.S.C. 1395nn(b)), as amended by section
8 15101(b)(3)(C), subsection (d)(1), subsection (e)(1), and
9 subsection (f), is amended—

10 (1) by redesignating paragraphs (7) through
11 (10) as paragraphs (8) through (11); and

12 (2) by inserting after paragraph (6) the follow-
13 ing new paragraph:

14 “(7) SERVICES FURNISHED IN RENAL DIALYSIS
15 FACILITIES.—In the case of a designated health
16 service furnished in a renal dialysis facility under
17 section 1881.”.

18 (h) NEW EXCEPTION FOR SERVICES FURNISHED IN
19 A HOSPICE.—Section 1877(b) (42 U.S.C. 1395nn(b)), as
20 amended by section 15101(b)(3)(C), subsection (d)(1),
21 subsection (e)(1), subsection (f), and subsection (g), is
22 amended—

23 (1) by redesignating paragraphs (8) through
24 (11) as paragraphs (9) through (12); and

(2) by inserting after paragraph (7) the following new paragraph:

“(8) SERVICES FURNISHED BY A HOSPICE PROGRAM.—In the case of a designated health service furnished by a hospice program under section 1861(dd)(2).”.

(i) NEW EXCEPTION FOR SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15101(b)(3)(C), subsection (d)(1), subsection (e)(1), subsection (f), subsection (g), and subsection (h), is amended—

(1) by redesignating paragraphs (9) through (12) as paragraphs (10) through (13); and

(2) by inserting after paragraph (8) the following new paragraph:

“(9) SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—In the case of a designated health service furnished in a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2)).”.

(i) DEFINITION OF REFERRAL.—Section 1877(h)(5)(A) (42 U.S.C. 1395nn(h)(5)(A)) is amended—

1 (1) by striking “an item or service” and insert-
2 ing “a designated health service”, and

3 (2) by striking “the item or service” and insert-
4 ing “the designated health service”.

5 **SEC. 15105. REPEAL OF REPORTING REQUIREMENTS.**

6 Section 1877 (42 U.S.C. 1395nn) is amended—

7 (1) by striking subsection (f); and

8 (2) by striking subsection (g)(5).

9 **SEC. 15106. PREEMPTION OF STATE LAW.**

10 Section 1877 (42 U.S.C. 1395nn) is amended by add-
11 ing at the end the following new subsection:

12 “(i) PREEMPTION OF STATE LAW.—This section pre-
13 empts State law to the extent State law is inconsistent
14 with this section.”.

15 **SEC. 15107. EFFECTIVE DATE.**

16 Except as provided in section 15103(b), the amend-
17 ments made by this part shall apply to referrals made on
18 or after August 14, 1995, regardless of whether or not
19 regulations are promulgated to carry out such amend-
20 ments.

21 **PART 2—ANTITRUST REFORM**

22 **SEC. 15111. PUBLICATION OF ANTITRUST GUIDELINES ON**
23 **ACTIVITIES OF HEALTH PLANS.**

24 (a) IN GENERAL.—The Attorney General shall pro-
25 vide for the development and publication of explicit guide-

1 lines on the application of antitrust laws to the activities
2 of health plans. The guidelines shall be designed to facili-
3 tate development and operation of plans, consistent with
4 the antitrust laws.

5 (b) REVIEW PROCESS.—The Attorney General shall
6 establish a review process under which the administrator
7 or sponsor of a health plan (or organization that proposes
8 to administer or sponsor a health plan) may submit a re-
9 quest to the Attorney General to obtain a prompt opinion
10 (but in no event later than 90 days after the Attorney
11 General receives the request) from the Department of Jus-
12 tice on the plan's conformity with the Federal antitrust
13 laws.

14 **SEC. 15112. ISSUANCE OF HEALTH CARE CERTIFICATES OF**
15 **PUBLIC ADVANTAGE.**

16 (a) ISSUANCE AND EFFECT OF CERTIFICATE.—The
17 Attorney General, after consultation with the Secretary,
18 shall issue in accordance with this section a certificate of
19 public advantage to each eligible health care collaborative
20 activity that complies with the requirements in effect
21 under this section on or after the expiration of the 1-year
22 period that begins on the date of the enactment of this
23 Act (without regard to whether or not the Attorney Gen-
24 eral has promulgated regulations to carry out this section
25 by such date). Such activity, and the parties to such activ-

1 ity, shall not be liable under any of the antitrust laws for
2 conduct described in such certificate and engaged in by
3 such activity if such conduct occurs while such certificate
4 is in effect.

5 (b) REQUIREMENTS APPLICABLE TO ISSUANCE OF
6 CERTIFICATES.—

7 (1) STANDARDS TO BE MET.—The Attorney
8 General shall issue a certificate to an eligible health
9 care collaborative activity if the Attorney General
10 finds that—

11 (A) the benefits that are likely to result
12 from carrying out the activity outweigh the re-
13 duction in competition (if any) that is likely to
14 result from the activity, and

15 (B) such reduction in competition is nec-
16 essary to obtain such benefits.

17 (2) FACTORS TO BE CONSIDERED.—

18 (A) WEIGHING OF BENEFITS AGAINST RE-
19 Duction IN COMPETITION.—For purposes of
20 making the finding described in paragraph
21 (1)(A), the Attorney General shall consider
22 whether the activity is likely—

23 (i) to maintain or to increase the
24 quality of health care by providing new

services not currently offered in the relevant market,

(ii) to increase access to health care,
(iii) to achieve cost efficiencies that will be passed on to health care consumers, such as economies of scale, reduced transaction costs, and reduced administrative costs, that cannot be achieved by the provision of available services and facilities in the relevant market,

(iv) to preserve the operation of health care facilities located in underserved geographical areas,

(v) to improve utilization of health care resources, and

(vi) to reduce inefficient health care resource duplication.

(B) NECESSITY OF REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(B), the Attorney General shall consider—

(i) the ability of the providers of health care services that are (or likely to be) affected by the health care collaborative activity and the entities responsible

1 for making payments to such providers to
2 negotiate societally optimal payment and
3 service arrangements,

4 (ii) the effects of the health care col-
5 laborative activity on premiums and other
6 charges imposed by the entities described
7 in clause (i), and

8 (iii) the availability of equally effi-
9 cient, less restrictive alternatives to achieve
10 the benefits that are intended to be
11 achieved by carrying out the activity.

12 (c) ESTABLISHMENT OF CRITERIA AND PROCE-
13 DURES.—Subject to subsections (d) and (e), not later than
14 1 year after the date of the enactment of this Act, the
15 Attorney General and the Secretary shall establish jointly
16 by rule the criteria and procedures applicable to the issu-
17 ance of certificates under subsection (a). The rules shall
18 specify the form and content of the application to be sub-
19 mitted to the Attorney General to request a certificate,
20 the information required to be submitted in support of
21 such application, the procedures applicable to denying and
22 to revoking a certificate, and the procedures applicable to
23 the administrative appeal (if such appeal is authorized by
24 rule) of the denial and the revocation of a certificate. Such
25 information may include the terms of the health care col-

1 laborative activity (in the case of an activity in existence
2 as of the time of the application) and implementation plan
3 for the collaborative activity.

4 (d) ELIGIBLE HEALTH CARE COLLABORATIVE AC-
5 TIVITY.—To be an eligible health care collaborative activ-
6 ity for purposes of this section, a health care collaborative
7 activity shall submit to the Attorney General an applica-
8 tion that complies with the rules in effect under subsection
9 (c) and that includes—

10 (1) an agreement by the parties to the activity
11 that the activity will not foreclose competition by en-
12 tering into contracts that prevent health care provid-
13 ers from providing health care in competition with
14 the activity,

15 (2) an agreement that the activity will submit
16 to the Attorney General annually a report that de-
17 scribes the operations of the activity and information
18 regarding the impact of the activity on health care
19 and on competition in health care, and

20 (3) an agreement that the parties to the activity
21 will notify the Attorney General and the Secretary of
22 the termination of the activity not later than 30
23 days after such termination occurs.

24 (e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—
25 Not later than 90 days after an eligible health care col-

1 laborative activity submits to the Attorney General an ap-
 2 plication that complies with the rules in effect under sub-
 3 section (c) and with subsection (d), the Attorney General
 4 shall issue or deny the issuance of such certificate. If, be-
 5 fore the expiration of such 90-day period, the Attorney
 6 General may extend the time for issuance for good cause.

7 (f) REVOCATION OF CERTIFICATE.—Whenever the
 8 Attorney General finds that a health care collaborative ac-
 9 tivity with respect to which a certificate is in effect does
 10 not meet the standards specified in subsection (b), the At-
 11 torney General shall revoke such certificate.

12 (g) WRITTEN REASONS; JUDICIAL REVIEW.—

13 (1) DENIAL AND REVOCATION OF CERTIFI-
 14 CATES.—If the Attorney General denies an applica-
 15 tion for a certificate or revokes a certificate, the At-
 16 torney General shall include in the notice of denial
 17 or revocation a statement of the reasons relied upon
 18 for the denial or revocation of such certificate.

19 (2) JUDICIAL REVIEW.—

20 (A) AFTER ADMINISTRATIVE PROCEED-
 21 ING.—(i) If the Attorney General denies an ap-
 22 plication submitted or revokes a certificate is-
 23 sued under this section after an opportunity for
 24 hearing on the record, then any party to the
 25 health care collaborative activity involved may

commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

(ii) As part of the Attorney General's answer, the Attorney General shall file in such court a certified copy of the record on which such denial or revocation is based. The findings of fact of the Attorney General may be set aside only if found to be unsupported by substantial evidence in such record taken as a whole.

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney General denies an application submitted or revokes a certificate issued under this section without an opportunity for hearing on the record, then any party to the health care collaborative activity involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for de novo review of such denial or revocation.

(h) EXEMPTION.—A person shall not be liable under any of the antitrust laws for conduct necessary—

1 (1) to prepare, agree to prepare, or attempt to
2 agree to prepare an application to request a certifi-
3 cate under this section, or

4 (2) to attempt to enter into any health care col-
5 laborative activity with respect to which such a cer-
6 tificate is in effect.

7 (i) DEFINITIONS.—In this section:

8 (1) The term “certificate” means a certificate
9 of public advantage authorized to be issued under
10 subsection (a).

11 (2) The term “health care collaborative activ-
12 ity” means an agreement (whether existing or pro-
13 posed) between 2 or more providers of health care
14 services that is entered into solely for the purpose of
15 sharing in the provision and coordination of health
16 care services and that involves substantial integra-
17 tion and financial risk-sharing between the parties,
18 but does not include the exchanging of information,
19 the entering into of any agreement, or the engage-
20 ment in any other conduct that is not reasonably re-
21 quired to carry out such agreement.

22 (3) The term “health care services” includes
23 services related to the delivery or administration of
24 health care services.

(4) The term “liable” means liable for any civil or criminal violation of the antitrust laws.

(5) The term “provider of health care services” means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

SEC. 15113. STUDY OF IMPACT ON COMPETITION.

The Attorney General, in consultation with the Chairman of the Federal Trade Commission, annually shall submit to the Congress a report as part of the annual budget oversight proceedings concerning the Antitrust Division of the Department of Justice. The report shall enable the Congress to determine how enforcement of antitrust laws is affecting the formation of efficient, cost-saving joint ventures and if the certificate of public advantage procedure set forth in section 15112 has resulted in undesirable reduction in competition in the health care marketplace. The report shall include an evaluation of the factors set forth in paragraphs (2)(A) and (2)(B) of section 15112(b).

SEC. 15114. ANTITRUST EXEMPTION.

The antitrust laws shall not apply with respect to—

1 (1) the merger of, or the attempt to merge, 2
2 or more hospitals,

3 (2) a contract entered into solely by 2 or more
4 hospitals to allocate hospital services, or

5 (3) the attempt by only 2 or more hospitals to
6 enter into a contract to allocate hospital services,
7 if each of such hospitals satisfies all of the requirements
8 of section 15115 at the time such hospitals engage in the
9 conduct described in paragraph (1), (2), or (3), as the case
10 may be.

11 **SEC. 15115. REQUIREMENTS.**

12 The requirements referred to in section 15114 are as
13 follows:

14 (1) The hospital is located outside of a city, or
15 in a city that has less than 150,000 inhabitants, as
16 determined in accordance with the most recent data
17 available from the Bureau of the Census.

18 (2) In the most recently concluded calendar
19 year, the hospital received more than 40 percent of
20 its gross revenue from payments made under Fed-
21 eral programs.

22 (3) There is in effect with respect to the hos-
23 pital a certificate issued by the Health Care Financ-
24 ing Administration specifying that such Administra-
25 tion has determined that Federal expenditures would

be reduced, consumer costs would not increase, and access to health care services would not be reduced, if the hospital and the other hospitals that requested such certificate merge, or allocate the hospital services specified in such request, as the case may be.

SEC. 15116. DEFINITION.

For purposes of this subtitle, the term ‘antitrust laws’ has the meaning given such term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies with respect to unfair methods of competition.

PART 3—MALPRACTICE REFORM

Subpart A—Uniform Standards for Malpractice

Claims

SEC. 15121. APPLICABILITY.

Except as provided in section 15131, this subpart shall apply to any medical malpractice liability action brought in a Federal or State court, and to any medical malpractice claim subject to an alternative dispute resolution system, that is initiated on or after January 1, 1996.

1 **SEC. 15122. REQUIREMENT FOR INITIAL RESOLUTION OF**
 2 **ACTION THROUGH ALTERNATIVE DISPUTE**
 3 **RESOLUTION.**

4 (a) IN GENERAL.—

5 (1) STATE CASES.—A medical malpractice li-
 6 ability action may not be brought in any State court
 7 during a calendar year unless the medical mal-
 8 practice liability claim that is the subject of the ac-
 9 tion has been initially resolved under an alternative
 10 dispute resolution system certified for the year by
 11 the Secretary under section 15132(a), or, in the case
 12 of a State in which such a system is not in effect
 13 for the year, under the alternative Federal system
 14 established under section 15132(b).

15 (2) FEDERAL DIVERSITY ACTIONS.—A medical
 16 malpractice liability action may not be brought in
 17 any Federal court under section 1332 of title 28,
 18 United States Code, during a calendar year unless
 19 the medical malpractice liability claim that is the
 20 subject of the action has been initially resolved
 21 under the alternative dispute resolution system re-
 22 ferred to in paragraph (1) that applied in the State
 23 whose law applies in such action.

24 (3) CLAIMS AGAINST UNITED STATES.—

25 (A) ESTABLISHMENT OF PROCESS FOR
 26 CLAIMS.—The Attorney General shall establish

an alternative dispute resolution process for the resolution of tort claims consisting of medical malpractice liability claims brought against the United States under chapter 171 of title 28, United States Code. Under such process, the resolution of a claim shall occur after the completion of the administrative claim process applicable to the claim under section 2675 of such title.

(B) REQUIREMENT FOR INITIAL RESOLUTION UNDER PROCESS.—A medical malpractice liability action based on a medical malpractice liability claim described in subparagraph (A) may not be brought in any Federal court unless the claim has been initially resolved under the alternative dispute resolution process established by the Attorney General under such subparagraph.

(b) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of subsection (a), an action is “initially resolved” under an alternative dispute resolution system if—

(1) the ADR reaches a decision on whether the defendant is liable to the plaintiff for damages; and

1 (2) if the ADR determines that the defendant
2 is liable, the ADR reaches a decision on the amount
3 of damages assessed against the defendant.

4 (c) PROCEDURES FOR FILING ACTIONS.—

5 (1) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is is-
6 sued with respect to a medical malpractice liability
7 claim under an alternative dispute resolution system,
8 each party affected by the decision shall submit a
9 sealed statement to a court of competent jurisdiction
10 indicating whether or not the party intends to con-
11 test the decision.

13 (2) DEADLINE FOR FILING ACTION.—A medical
14 malpractice liability action may not be brought by a
15 party unless—

16 (A) the party has filed the notice of intent
17 required by paragraph (1); and

18 (B) the party files the action in a court of
19 competent jurisdiction not later than 90 days
20 after the decision resolving the medical mal-
21 practice liability claim that is the subject of the
22 action is issued under the applicable alternative
23 dispute resolution system.

(3) COURT OF COMPETENT JURISDICTION.—

For purposes of this subsection, the term “court of competent jurisdiction” means—

(A) with respect to actions filed in a State court, the appropriate State trial court; and

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(d) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—

The decision reached under an alternative dispute resolution system shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of a medical malpractice liability action adjudicated in a State or Federal trial court. The previous sentence shall not apply to a decision that is contested by a party affected by the decision pursuant to subsection (c)(1).

SEC. 15123. OPTIONAL APPLICATION OF PRACTICE GUIDELINES.

(a) DEVELOPMENT AND CERTIFICATION OF GUIDELINES.—Each State may develop, for certification by the Secretary, a set of specialty clinical practice guidelines, based on recommended guidelines from national specialty societies, to be updated annually. In the absence of recommended guidelines from such societies, each State may

1 develop such guidelines based on such criteria as the State
2 considers appropriate (including based on recommended
3 guidelines developed by the Agency for Health Care Policy
4 and Research).

5 (b) PROVISION OF HEALTH CARE UNDER GUIDE-
6 LINES.—Notwithstanding any other provision of law, in
7 any medical malpractice liability action arising from the
8 conduct of a health care provider or health care profes-
9 sional, if such conduct was in accordance with a guideline
10 developed by the State in which the conduct occurred and
11 certified by the Secretary under subsection (a), the guide-
12 line—

13 (1) may be introduced by any party to the ac-
14 tion (including a health care provider, health care
15 professional, or patient); and

16 (2) if introduced, shall establish a rebuttable
17 presumption that the conduct was in accordance
18 with the appropriate standard of medical care, which
19 may only be overcome by the presentation of clear
20 and convincing evidence on behalf of the party
21 against whom the presumption operates.

22 **SEC. 15124. TREATMENT OF NONECONOMIC AND PUNITIVE**
23 **DAMAGES.**

24 (a) LIMITATION ON NONECONOMIC DAMAGES.—The
25 total amount of noneconomic damages that may be award-

1 ed to a claimant and the members of the claimant's family
2 for losses resulting from the injury which is the subject
3 of a medical malpractice liability action may not exceed
4 \$250,000, regardless of the number of parties against
5 whom the action is brought or the number of actions
6 brought with respect to the injury.

7 (b) NO AWARD OF PUNITIVE DAMAGES AGAINST
8 MANUFACTURER OF MEDICAL PRODUCT.—In the case of
9 a medical malpractice liability action in which the plaintiff
10 alleges a claim against the manufacturer of a medical
11 product, no punitive or exemplary damages may be award-
12 ed against such manufacturer.

13 (c) JOINT AND SEVERAL LIABILITY FOR NON-
14 ECONOMIC DAMAGES.—The liability of each defendant for
15 noneconomic damages shall be several only and shall not
16 be joint, and each defendant shall be liable only for the
17 amount of noneconomic damages allocated to the defend-
18 ant in direct proportion to the defendant's percentage of
19 responsibility (as determined by the trier of fact).

20 (d) USE OF PUNITIVE DAMAGE AWARDS FOR OPER-
21 ATION OF ADR SYSTEMS IN STATES.—

22 (1) IN GENERAL.—The total amount of any pu-
23 nitive damages awarded in a medical malpractice li-
24 ability action shall be paid to the State in which the
25 action is brought (or, in a case brought in Federal

1 court, in the State in which the health care services
2 that caused the injury that is the subject of the ac-
3 tion were provided), and shall be used by the State
4 solely to implement and operate the State alternative
5 dispute resolution system certified by the Secretary
6 under section 15132 (except as provided in para-
7 graph (2)).

8 (2) USE OF REMAINING AMOUNTS FOR PRO-
9 VIDER LICENSING AND DISCIPLINARY ACTIVITIES.—

10 If the amount of punitive damages paid to a State
11 under paragraph (1) for a year is greater than the
12 State's costs of implementing and operating the
13 State alternative dispute resolution system during
14 the year, the balance of such punitive damages paid
15 to the State shall be used solely to carry out activi-
16 ties to assure the safety and quality of health care
17 services provided in the State, including (but not
18 limited to)—

19 (A) licensing or certifying health care pro-
20 fessionals and health care providers in the
21 State; and

22 (B) carrying out programs to reduce mal-
23 practice-related costs for providers volunteering
24 to provide services in medically underserved
25 areas.

(3) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to paragraph (1) to supplement and not to replace amounts spent by the State for implementing and operating the State alternative dispute resolution system or carrying out the activities described in paragraph (2).

(e) DRUGS AND DEVICES.—

(1)(A) Punitive damages shall not be awarded against a manufacturer or product seller of a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) which caused the claimant's harm where—

(i) such drug or device was subject to pre-market approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm or the adequacy of the packaging or labeling of such drug or device, and such drug was approved by the Food and Drug Administration; or

1 (ii) the drug is generally recognized as safe
2 and effective pursuant to conditions established
3 by the Food and Drug Administration and ap-
4 plicable regulations, including packaging and la-
5 beling regulations.

6 (B) Subparagraph (A) shall not apply in any
7 case in which the defendant, before or after pre-
8 market approval of a drug or device—

9 (i) intentionally and wrongfully withheld
10 from or misrepresented to the Food and Drug
11 Administration information concerning such
12 drug or device required to be submitted under
13 the Federal Food, Drug, and Cosmetic Act (21
14 U.S.C. 301 et seq.) or section 351 of the Public
15 Health Service Act (42 U.S.C. 262) that is ma-
16 terial and relevant to the harm suffered by the
17 claimant, or

18 (ii) made an illegal payment to an official
19 or employee of the Food and Drug Administra-
20 tion for the purpose of securing or maintaining
21 approval of such drug or device.

22 (2) PACKAGING.—In a product liability action
23 for harm which is alleged to relate to the adequacy
24 of the packaging (or labeling relating to such pack-
25 aging) of a drug which is required to have tamper-

resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer of the drug shall not be held liable for punitive damages unless the drug is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

SEC. 15125. PERIODIC PAYMENTS FOR FUTURE LOSSES.

(a) IN GENERAL.—In any medical malpractice liability action in which the damages awarded for future economic loss exceeds \$100,000, a defendant may not be required to pay such damages in a single, lump-sum payment, but may be permitted to make such payments on a periodic basis. The periods for such payments shall be determined by the court, based upon projections of when such expenses are likely to be incurred.

(b) WAIVER.—A court may waive the application of subsection (a) with respect to a defendant if the court determines that it is not in the best interests of the plaintiff to receive payments for damages on such a periodic basis.

SEC. 15126. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

1 (1) IN GENERAL.—The court in a medical mal-
 2 practice liability action shall require the party that
 3 (pursuant to section 15122(c)(1)) contested the rul-
 4 ing of the alternative dispute resolution system with
 5 respect to the medical malpractice liability claim
 6 that is the subject of the action to pay to the oppos-
 7 ing party the costs incurred by the opposing party
 8 under the action, including attorney's fees, fees paid
 9 to expert witnesses, and other litigation expenses
 10 (but not including court costs, filing fees, or other
 11 expenses paid directly by the party to the court, or
 12 any fees or costs associated with the resolution of
 13 the claim under the alternative dispute resolution
 14 system), but only if—

15 (A) in the case of an action in which the
 16 party that contested the ruling is the claimant,
 17 the amount of damages awarded to the party
 18 under the action is less than the amount of
 19 damages awarded to the party under the ADR
 20 system; and

21 (B) in the case of an action in which the
 22 party that contested the ruling is the defendant,
 23 the amount of damages assessed against the
 24 party under the action is greater than the

1 amount of damages assessed under the ADR
2 system.

3 (2) EXCEPTIONS.—Paragraph (1) shall not
4 apply if—

5 (A) the party contesting the ruling made
6 under the previous alternative dispute resolu-
7 tion system shows that—

8 (i) the ruling was procured by corrup-
9 tion, fraud, or undue means,

10 (ii) there was partiality or corruption
11 under the system,

12 (iii) there was other misconduct under
13 the system that materially prejudiced the
14 party's rights, or

15 (iv) the ruling was based on an error
16 of law;

17 (B) the party contesting the ruling made
18 under the alternative dispute resolution system
19 presents new evidence before the trier of fact
20 that was not available for presentation under
21 the ADR system;

22 (C) the medical malpractice liability action
23 raised a novel issue of law; or

24 (D) the court finds that the application of
25 such paragraph to a party would constitute an

1 undue hardship, and issues an order waiving or
2 modifying the application of such paragraph
3 that specifies the grounds for the court's deci-
4 sion.

5 (3) LIMIT ON ATTORNEYS' FEES PAID.—Attor-
6 neys' fees that are required to be paid under para-
7 graph (1) by the contesting party shall not exceed
8 the amount of the attorneys' fees incurred by the
9 contesting party in the action. If the attorneys' fees
10 of the contesting party are based on a contingency
11 fee agreement, the amount of attorneys' fees for
12 purposes of the preceding sentence shall not exceed
13 the reasonable value of those services.

14 (4) RECORDS.—In order to receive attorneys'
15 fees under paragraph (1), counsel of record in the
16 medical malpractice liability action involved shall
17 maintain accurate, complete records of hours worked
18 on the action, regardless of the fee arrangement
19 with the client involved.

20 (b) CONTINGENCY FEE DEFINED.—As used in this
21 section, the term "contingency fee" means any fee for pro-
22 fessional legal services which is, in whole or in part, con-
23 tingent upon the recovery of any amount of damages,
24 whether through judgment or settlement.

1 **SEC. 15127. UNIFORM STATUTE OF LIMITATIONS.**

2 (a) IN GENERAL.—Except as provided in subsection
 3 (b), no medical malpractice claim may be initiated after
 4 the expiration of the 2-year period that begins on the date
 5 on which the alleged injury that is the subject of such
 6 claim was discovered, but in no event may such a claim
 7 be initiated after the expiration of the 4-year period that
 8 begins on the date on which the alleged injury that is the
 9 subject of such claim occurred.

10 (b) EXCEPTION FOR MINORS.—In the case of an al-
 11 leged injury suffered by a minor who has not attained 6
 12 years of age, a medical malpractice claim may not be initi-
 13 ated after the expiration of the 2-year period that begins
 14 on the date on which the alleged injury that is the subject
 15 of such claim was discovered or should reasonably have
 16 been discovered, but in no event may such a claim be initi-
 17 ated after the date on which the minor attains 12 years
 18 of age.

19 **SEC. 15128. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**
 20 **SERVICES.**

21 (a) IN GENERAL.—In the case of a medical mal-
 22 practice claim relating to services provided during labor
 23 or the delivery of a baby, if the health care professional
 24 or health care provider against whom the claim is brought
 25 did not previously treat the claimant for the pregnancy,
 26 the trier of fact may not find that such professional or

1 provider committed malpractice and may not assess dam-
 2 ages against such professional or provider unless the mal-
 3 practice is proven by clear and convincing evidence.

4 (b) **APPLICABILITY TO GROUP PRACTICES OR**
 5 **AGREEMENTS AMONG PROVIDERS.**—For purposes of sub-
 6 section (a), a health care professional shall be considered
 7 to have previously treated an individual for a pregnancy
 8 if the professional is a member of a group practice whose
 9 members previously treated the individual for the preg-
 10 nancy or is providing services to the individual during
 11 labor or the delivery of a baby pursuant to an agreement
 12 with another professional.

13 **SEC. 15129. JURISDICTION OF FEDERAL COURTS.**

14 Nothing in this subpart shall be construed to estab-
 15 lish any jurisdiction over any medical malpractice liability
 16 action in the district courts of the United States on the
 17 basis of sections 1331 or 1337 of title 28, United States
 18 Code.

19 **SEC. 15130. PREEMPTION.**

20 (a) **IN GENERAL.**—The provisions of this subpart
 21 shall preempt any State law to the extent such law is in-
 22 consistent with such provisions, except that the provisions
 23 of this subpart shall not preempt any State law that pro-
 24 vides for defenses or places limitations on a person's liabil-
 25 ity in addition to those contained in this part, places great-

1 er limitations on the amount of attorneys' fees that can
2 be collected, or otherwise imposes greater restrictions than
3 those provided in this part.

4 (b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE
5 OF LAW OR VENUE.—Nothing in this subpart shall be
6 construed to—

7 (1) waive or affect any defense of sovereign im-
8 munity asserted by any State under any provision of
9 law;

10 (2) waive or affect any defense of sovereign im-
11 munity asserted by the United States;

12 (3) affect the applicability of any provision of
13 the Foreign Sovereign Immunities Act of 1976;

14 (4) preempt State choice-of-law rules with re-
15 spect to claims brought by a foreign nation or a citi-
16 zen of a foreign nation; or

17 (5) affect the right of any court to transfer
18 venue or to apply the law of a foreign nation or to
19 dismiss a claim of a foreign nation or of a citizen
20 of a foreign nation on the ground in inconvenient
21 forum.

1 **Subpart B—Requirements for State Alternative**

2 **Dispute Resolution Systems (ADR)**

3 **SEC. 15131. BASIC REQUIREMENTS.**

4 (a) IN GENERAL.—A State's alternative dispute reso-
5 lution system meets the requirements of this section if the
6 system—

7 (1) applies to all medical malpractice liability
8 claims under the jurisdiction of the courts of that
9 State;

10 (2) requires that a written opinion resolving the
11 dispute be issued not later than 6 months after the
12 date by which each party against whom the claim is
13 filed has received notice of the claim (other than in
14 exceptional cases for which a longer period is re-
15 quired for the issuance of such an opinion), and that
16 the opinion contain—

17 (A) findings of fact relating to the dispute,
18 and

19 (B) a description of the costs incurred in
20 resolving the dispute under the system (includ-
21 ing any fees paid to the individuals hearing and
22 resolving the claim), together with an appro-
23 priate assessment of the costs against any of
24 the parties;

25 (3) requires individuals who hear and resolve
26 claims under the system to meet such qualifications

1 as the State may require (in accordance with regula-
2 tions of the Secretary);

3 (4) is approved by the State or by local govern-
4 ments in the State;

5 (5) with respect to a State system that consists
6 of multiple dispute resolution procedures—

7 (A) permits the parties to a dispute to se-
8 lect the procedure to be used for the resolution
9 of the dispute under the system, and

10 (B) if the parties do not agree on the pro-
11 cedure to be used for the resolution of the dis-
12 pute, assigns a particular procedure to the
13 parties;

14 (6) provides for the transmittal to the State
15 agency responsible for monitoring or disciplining
16 health care professionals and health care providers
17 of any findings made under the system that such a
18 professional or provider committed malpractice, un-
19 less, during the 90-day period beginning on the date
20 the system resolves the claim against the profes-
21 sional or provider, the professional or provider
22 brings an action contesting the decision made under
23 the system; and

24 (7) provides for the regular transmittal to the
25 Administrator for Health Care Policy and Research

1 of information on disputes resolved under the sys-
2 tem, in a manner that assures that the identity of
3 the parties to a dispute shall not be revealed.

4 (b) APPLICATION OF MALPRACTICE LIABILITY
5 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—

6 The provisions of subpart A (other than section 15122)
7 shall apply with respect to claims brought under a State
8 alternative dispute resolution system or the alternative
9 Federal system in the same manner as such provisions
10 apply with respect to medical malpractice liability actions
11 brought in the State.

12 **SEC. 15132. CERTIFICATION OF STATE SYSTEMS; APPLICA-**
13 **BILITY OF ALTERNATIVE FEDERAL SYSTEM.**

14 (a) CERTIFICATION.—

15 (1) IN GENERAL.—Not later than October 1 of
16 each year (beginning with 1995), the Secretary, in
17 consultation with the Attorney General, shall deter-
18 mine whether a State's alternative dispute resolution
19 system meets the requirements of this subpart for
20 the following calendar year.

21 (2) BASIS FOR CERTIFICATION.—The Secretary
22 shall certify a State's alternative dispute resolution
23 system under this subsection for a calendar year if
24 the Secretary determines under paragraph (1) that
25 the system meets the requirements of section 15131,

including the requirement described in section 15124 that punitive damages awarded under the system are paid to the State for the uses described in such section.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—

Not later than October 1, 1995, the Secretary, in consultation with the Attorney General, shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (a) for the year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section 15131(a) shall apply to claims brought under the system;

(B) if the system provides for the resolution of claims through arbitration, the claims brought under the system shall be heard and resolved by arbitrators appointed by the Sec-

1 retary in consultation with the Attorney Gen-
2 eral; and

3 (C) with respect to a State in which the
4 system is in effect, the Secretary may (at the
5 State's request) modify the system to take into
6 account the existence of dispute resolution pro-
7 cedures in the State that affect the resolution
8 of medical malpractice liability claims.

9 (3) TREATMENT OF STATES WITH ALTER-
10 NATIVE SYSTEM IN EFFECT.—If the alternative Fed-
11 eral ADR system established under this subsection is
12 applied with respect to a State for a calendar year,
13 the State shall make a payment to the United States
14 (at such time and in such manner as the Secretary
15 may require) in an amount equal to 110 percent of
16 the costs incurred by the United States during the
17 year as a result of the application of the system with
18 respect to the State.

19 **SEC. 15133. REPORTS ON IMPLEMENTATION AND EFFEC-**
20 **TIVENESS OF ALTERNATIVE DISPUTE RESO-**
21 **LUTION SYSTEMS.**

22 (a) IN GENERAL.—Not later than 5 years after the
23 date of the enactment of this Act, the Secretary shall pre-
24 pare and submit to the Congress a report describing and
25 evaluating State alternative dispute resolution systems op-

1 erated pursuant to this subpart and the alternative Fed-
2 eral system established under section 15132(b).

3 (b) CONTENTS OF REPORT.—The Secretary shall in-
4 clude in the report prepared and submitted under sub-
5 section (a)—

6 (1) information on—

7 (A) the effect of the alternative dispute
8 resolution systems on the cost of health care
9 within each State,

10 (B) the impact of such systems on the ac-
11 cess of individuals to health care within the
12 State, and

13 (C) the effect of such systems on the qual-
14 ity of health care provided within the State; and

15 (2) to the extent that such report does not pro-
16 vide information on no-fault systems operated by
17 States as alternative dispute resolution systems pur-
18 suant to this part, an analysis of the feasibility and
19 desirability of establishing a system under which
20 medical malpractice liability claims shall be resolved
21 on a no-fault basis.

22 **Subpart C—Definitions**

23 **SEC. 15141. DEFINITIONS.**

24 As used in this part:

1 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
2 TEM.—The term “alternative dispute resolution sys-
3 tem” means a system that is enacted or adopted by
4 a State to resolve medical malpractice claims other
5 than through a medical malpractice liability action.

6 (2) CLAIMANT.—The term “claimant” means
7 any person who brings a health care liability action
8 and, in the case of an individual who is deceased, in-
9 competent, or a minor, the person on whose behalf
10 such an action is brought.

11 (3) CLEAR AND CONVINCING EVIDENCE.—The
12 term “clear and convincing evidence” is that meas-
13 ure or degree of proof that will produce in the mind
14 of the trier of fact a firm belief or conviction as to
15 the truth of the allegations sought to be established,
16 except that such measure or degree of proof is more
17 than that required under preponderance of the evi-
18 dence, but less than that required for proof beyond
19 a reasonable doubt.

20 (4) ECONOMIC DAMAGES.—The term “economic
21 damages” means damages paid to compensate an in-
22 dividual for losses for hospital and other medical ex-
23 penses, lost wages, lost employment, and other pecu-
24 niary losses.

(5) HEALTH CARE PROFESSIONAL.—The term “health care professional” means any individual who provides health care services in a State and who is required by State law or regulation to be licensed or certified by the State to provide such services in the State.

(6) HEALTH CARE PROVIDER.—The term “health care provider” means any organization or institution that is engaged in the delivery of health care services in a State that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(7) INJURY.—The term “injury” means any illness, disease, or other harm that is the subject of a medical malpractice claim.

(8) MEDICAL MALPRACTICE LIABILITY ACTION.—The term “medical malpractice liability action” means any civil action brought pursuant to State law in which a plaintiff alleges a medical malpractice claim against a health care provider or health care professional, but does not include any action in which the plaintiff’s sole allegation is an allegation of an intentional tort.

1 (9) MEDICAL MALPRACTICE CLAIM.—The term
2 “medical malpractice claim” means any claim relat-
3 ing to the provision of (or the failure to provide)
4 health care services or the use of a medical product,
5 without regard to the theory of liability asserted,
6 and includes any third-party claim, cross-claim,
7 counterclaim, or contribution claim in a medical
8 malpractice liability action.

9 (10) MEDICAL PRODUCT.—

10 (A) IN GENERAL.—The term “medical
11 product” means, with respect to the allegation
12 of a claimant, a drug (as defined in section
13 201(g)(1) of the Federal Food, Drug, and Cos-
14 metic Act (21 U.S.C. 321(g)(1)) or a medical
15 device (as defined in section 201(h) of the Fed-
16 eral Food, Drug, and Cosmetic Act (21 U.S.C.
17 321(h)) if—

18 (i) such drug or device was subject to
19 premarket approval under section 505,
20 507, or 515 of the Federal Food, Drug,
21 and Cosmetic Act (21 U.S.C. 355, 357, or
22 360e) or section 351 of the Public Health
23 Service Act (42 U.S.C. 262) with respect
24 to the safety of the formulation or per-
25 formance of the aspect of such drug or de-

vice which is the subject of the claimant's allegation or the adequacy of the packaging or labeling of such drug or device, and such drug or device is approved by the Food and Drug Administration; or

(ii) the drug or device is generally recognized as safe and effective under regulations issued by the Secretary of Health and Human Services under section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p)).

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term “medical product” shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Administration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

(11) NONECONOMIC DAMAGES.—The term “noneconomic damages” means damages paid to compensate an individual for losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of

1 enjoyment of life, loss of consortium, and other
2 nonpecuniary losses, but does not include punitive
3 damages.

4 (12) PUNITIVE DAMAGES.—The term “punitive
5 damages” means compensation, in addition to com-
6 pensation for actual harm suffered, that is awarded
7 for the purpose of punishing a person for conduct
8 deemed to be malicious, wanton, willful, or exces-
9 sively reckless.

10 **PART 4—PAYMENT AREAS FOR PHYSICIANS’**

11 **SERVICES UNDER MEDICARE**

12 **SEC. 15151. MODIFICATION OF PAYMENT AREAS USED TO**
13 **DETERMINE PAYMENTS FOR PHYSICIANS’**
14 **SERVICES UNDER MEDICARE.**

15 (a) IN GENERAL.—Section 1848(j)(2) (42 U.S.C.
16 1395w@4(j)(2)) is amended to read as follows:

17 “(2) FEE SCHEDULE AREA.—

18 “(A) GENERAL RULE.—Except as provided
19 in subparagraph (B), the term ‘fee schedule
20 area’ means, with respect to physicians’ services
21 furnished in a State, the State.

22 “(B) EXCEPTION FOR STATES WITH HIGH-
23 EST VARIATION AMONG AREAS.—In the case of
24 the 15 States with the greatest variation in cost
25 associated with physicians’ services among var-

ious geographic areas of the State (as determined by the Secretary in accordance with such standards as the Secretary considers appropriate), the fee schedule area applicable with respect to physicians' services furnished in the State shall be a locality used under section 1842(b) for purposes of computing payment amounts for physicians' services, except that the Secretary shall revise the localities used under such section so that there are no more than 5 such localities in any State."

(b) BUDGET-NEUTRALITY REQUIREMENT.—The Secretary of Health and Human Services shall carry out the amendment made by subsection (a) in a manner which ensures that the aggregate amount of payment made for physicians' services under part B of the medicare program in any year does not exceed the aggregate amount of payment which would have been made for such services under part B during the year if the amendment were not in effect.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to physicians' services furnished on or after January 1, 1997.

1 Subtitle C—Medicare Payments to 2 Health Care Providers

3 PART 1—PROVISIONS AFFECTING ALL 4 PROVIDERS

5 SEC. 15201. ONE-YEAR FREEZE IN PAYMENTS TO PROVID- 6 ERS.

7 (a) FREEZE IN UPDATES.—

8 (1) IN GENERAL.—Notwithstanding any other
9 provision of law, except as otherwise provided in
10 paragraph (2), for purposes of determining the
11 amount to be paid for an item or service under title
12 XVIII of the Social Security Act, the percentage in-
13 crease in any economic index by which a payment
14 amount under title XVIII of the Social Security Act
15 is required to be increased during fiscal year 1996
16 shall be deemed to be zero.

17 (2) EXCEPTIONS.—Paragraph (1) shall not
18 apply—

19 (A) to payments for the operating costs of
20 inpatient hospital services of a subsection (d)
21 hospital (as defined in section 1886(d)(1)(B) of
22 the Social Security Act); or

23 (B) to the determination of hospital-spe-
24 cific FTE resident amounts under section
25 1886(h) of such Act.

1 (b) ECONOMIC INDEX.— The term “economic index”
2 includes—

3 (1) the hospital market basket index (described
4 in section 1886(b)(3)(B)(iii) of the Social Security
5 Act),

6 (2) the medicare economic index (referred to in
7 the fourth sentence of section 1842(b)(3) of such
8 Act),

9 (3) the consumer price index for all urban con-
10 sumers (U.S. city average), and

11 (4) any other index used to adjust payment
12 amounts under title XVIII of such Act.

13 (c) EXTENSION OF PAYMENT FREEZE FOR SNFS
14 AND HHAS.—

15 (1) SKILLED NURSING FACILITIES.—

16 (A) NO CHANGE IN COST LIMITS.—Section
17 13503(a)(1) of OBRA–1993 is amended by
18 striking “1994 and 1995” and inserting “1994,
19 1995, and 1996”.

20 (B) DELAY IN UPDATES; NO CATCHUP.—

21 The last sentence of section 1888(a) (42 U.S.C.
22 1395yy(a)) is amended—

23 (i) by striking “1995” and inserting
24 “1996”, and

1 (ii) by striking “subsection.” and in-
 2 sserting “subsection (except that such up-
 3 dates may not take into account any
 4 changes in the routine service costs of
 5 skilled nursing facilities during cost report-
 6 ing periods which began during fiscal year
 7 1994, 1995, or 1996).”.

8 (C) PROSPECTIVE PAYMENTS.—Section
 9 13505(b) of OBRA–1993 is amended by strik-
 10 ing “fiscal years 1994 and 1995” and inserting
 11 “fiscal years 1994, 1995, and 1996”.

12 (2) HOME HEALTH AGENCIES.—

13 (A) NO CHANGE IN COST LIMITS.—Section
 14 13564(a)(1) of OBRA–1993 is amended by
 15 striking “1996” and inserting “1997”.

16 (B) DELAY IN UPDATES; NO CATCHUP.—
 17 Section 1861(v)(1)(L)(iii) (42 U.S.C.
 18 1395x(v)(1)(L)(iii)) is amended—

19 (i) by striking “1996” and inserting
 20 “1997”, and

21 (ii) by adding at the end the follow-
 22 ing: “In establishing limits under this sub-
 23 paragraph, the Secretary may not take
 24 into account any changes in the routine
 25 service costs of the provision of services

furnished by home health agencies with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1997.”.

PART 2—PROVISIONS AFFECTING DOCTORS

SEC. 15211. UPDATING FEES FOR PHYSICIANS’ SERVICES.

(a) ESTABLISHMENT OF SINGLE, CUMULATIVE MVPS.— Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended—

(1) in subparagraphs (A) and (C) of paragraph (1), by striking “rates of increase for all physicians’ services and for each category of such services” each place it appears and inserting “rate of increase for all physicians’ services (and, in the case of fiscal years beginning before fiscal year 1996, for each category of such services)”; and

(2) in paragraph (2)—

(A) in subparagraph (A)—

(i) by striking “IN GENERAL.—” and inserting “FISCAL YEARS 1991 THROUGH 1995.—”,

(ii) in the matter preceding clause (i), by striking “a fiscal year (beginning with fiscal year 1991)” and inserting “fiscal years 1991 through 1995”, and

1 (iii) in the matter following clause
 2 (iv), by striking “subparagraph (B)) and
 3 inserting “subparagraph (C))”,
 4 (B) by redesignating subparagraphs (B)
 5 and (C) as subparagraphs (C) and (D), and
 6 (C) by inserting after subparagraph (A)
 7 the following:

8 “(B) FISCAL YEAR 1996 AND THERE-
 9 AFTER.—Unless Congress otherwise provides,
 10 the performance standard rate of increase for
 11 all physicians’ services for a fiscal year begin-
 12 ning with fiscal year 1996 shall be equal to the
 13 performance standard rate of increase deter-
 14 mined under this paragraph for the previous
 15 fiscal year, increased by the product of—

16 “(i) 1 plus the Secretary’s estimate of
 17 the weighted average percentage increase
 18 (divided by 100) in the fees for all physi-
 19 cians’ services under this part for portions
 20 of calendar years included in the fiscal
 21 year involved,

22 “(ii) 1 plus the Secretary’s estimate of
 23 the percentage increase or decrease (di-
 24 vided by 100) in the average number of in-
 25 dividuals enrolled under this part (other

than HMO enrollees) from the previous fiscal year to the fiscal year involved,

“(iii) 1 plus the Secretary’s estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physicians’ services under this part for the 5-fiscal-year-period ending with the preceding fiscal year, and

“(iv) 1 plus the Secretary’s estimate of the percentage increase or decrease (divided by 100) in expenditures for all physicians’ services in the fiscal year (compared with the previous fiscal year) that are estimated to result from changes in law or regulations affecting the percentage increase described in clause (i) and that is not taken into account in the percentage increase described in clause (i), minus 1, multiplied by 100, and reduced by the performance standard factor (specified in subparagraph (C)).”.

(b) ANNUAL UPDATE BASED ON CUMULATIVE PERFORMANCE.—

(1) IN GENERAL.—Section 1848(d)(3)(B) (42 U.S.C. 1395w-4(d)(3)(B)) is amended—

- 1 (A) in clause (i)—
- 2 (i) by striking “IN GENERAL.—” and
- 3 inserting “For 1992 through 1995”,
- 4 (ii) by striking “for a year” and in-
- 5 serting “for each of the years 1992
- 6 through 1995”, and
- 7 (iii) by striking “, subject to clause
- 8 (ii),” and inserting “subject to clause
- 9 (iii),”;
- 10 (B) by redesignating clause (ii) as clause
- 11 (iii); and
- 12 (C) by inserting after clause (i) the follow-
- 13 ing:
- 14 “(ii) YEARS BEGINNING AFTER
- 15 1996.—
- 16 “(I) IN GENERAL.—The update
- 17 for all physicians” services for a year
- 18 beginning after 1996 provided under
- 19 subparagraph (A) shall, subject to
- 20 clause (iii), be increased or decreased
- 21 by the same percentage by which the
- 22 cumulative percentage increase in ac-
- 23 tual expenditures for all physicians’
- 24 services in the second previous fiscal
- 25 year over the third previous fiscal

year, was less or greater, respectively, than the performance standard rate of increase (established under subsection (f)) for such services for the second previous fiscal year.

“(II) CUMULATIVE PERCENTAGE INCREASE DEFINED.—In subclause (I), the ‘cumulative percentage increase in actual expenditures’ for a year shall be equal to the product of the adjusted increases for each year beginning with 1995 up to and including the year involved, minus 1 and multiplied by 100. In the previous sentence, the ‘adjusted increase’ for a year is equal to 1 plus the percentage increase in actual expenditures for the year (over the preceding year).”.

(3) ESTABLISHMENT OF CONVERSION FACTOR FOR 1996.—Section 1848(d)(1) (42 U.S.C. 1395w-4(d)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (D); and

(B) by inserting after subparagraph (B) the following new subparagraph:

1 “(C) SPECIAL RULE FOR 1996.—For
2 1996, the conversion factor under this sub-
3 section shall be \$36.40 for all physicians’ serv-
4 ices.”.

5 (c) ESTABLISHING UPPER LIMIT ON MVPS RE-
6 WARDS.—

7 (1) IN GENERAL.—Clause (iii) of section
8 1848(d)(3)(B), as redesignated by subsection
9 (b)(1)(B), is amended by striking “a decrease” and
10 inserting “an increase or decrease”.

11 (2) EFFECTIVE DATE.—The amendment made
12 by paragraph (1) shall apply to physicians’ services
13 furnished on or after January 1, 1996.

14 **SEC. 15212. USE OF REAL GDP TO ADJUST FOR VOLUME**
15 **AND INTENSITY.**

16 Section 1848(f)(2)(B)(iii) (42 U.S.C. 1395w-
17 4(f)(2)(B)(iii)), as added by section 15211(a)(2)(C), is
18 amended to read as follows:

19 “(iii) 1 plus the average per capita
20 growth in the real gross domestic product
21 (divided by 100) for the 5-fiscal-year pe-
22 riod ending with the previous fiscal year
23 (increased by 1.5 percentage points for the
24 category of services consisting of primary
25 care services), and”.

PART 3—PROVISIONS AFFECTING HOSPITALS

SEC. 15221. REDUCTION IN UPDATE FOR INPATIENT HOSPITAL SERVICES.

(a) PPS HOSPITALS.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by amending subclause (XII) to read as follows:

“(XII) for each of the fiscal years 1997 through 2002, the market basket percentage increase minus 0.5 percentage point for hospitals in a rural area, and the market basket percentage increase minus 1.5 percentage points for all other hospitals, and”; and

(2) in subclause (XIII), by striking “1998” and inserting “2003”.

(b) PPS-EXEMPT HOSPITALS.—

(1) IN GENERAL.—Section 1886(b)(3)(B)(ii) (42 U.S.C. 1395ww(b)(3)(B)(ii)) is amended—

(A) in subclause (V)—

(i) by striking “through 1997” and inserting “through 1996”, and

(ii) by striking “and” at the end;

(B) by redesignating subclause (VI) as subclause (VII); and

(C) by inserting after subclause (V) the following new subclause:

1 “(VI) fiscal years 1997 through 2002, is the
2 market basket percentage increase minus 1.0 per-
3 centage point, and”.

4 (2) CONFORMING AMENDMENT.—Section
5 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is
6 amended by striking clause (v).

7 **SEC. 15222. ELIMINATION OF FORMULA-DRIVEN OVERPAY-**
8 **MENTS FOR CERTAIN OUTPATIENT HOSPITAL**
9 **SERVICES.**

10 (a) AMBULATORY SURGICAL CENTER PROCE-
11 DURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C.
12 1395l(i)(3)(B)(i)(II)) is amended—

13 (1) by striking “of 80 percent”; and

14 (2) by striking the period at the end and insert-
15 ing the following: “, less the amount a provider may
16 charge as described in clause (ii) of section
17 1866(a)(2)(A).”.

18 (b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCE-
19 DURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C.
20 1395l(n)(1)(B)(i)(II)) is amended—

21 (1) by striking “of 80 percent”; and

22 (2) by striking the period at the end and insert-
23 ing the following: “, less the amount a provider may
24 charge as described in clause (ii) of section
25 1866(a)(2)(A).”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished during por-
3 tions of cost reporting periods occurring on or after July
4 1, 1994.

5 **SEC. 15223. ESTABLISHMENT OF PROSPECTIVE PAYMENT**
6 **SYSTEM FOR OUTPATIENT SERVICES.**

7 (a) IN GENERAL.—Section 1833(a)(2)(B) (42 U.S.C.
8 1395l(a)(2)(B)) is amended by striking “section 1886)—
9 ” and all that follows and inserting the following: “section
10 1886), an amount equal to a prospectively determined
11 payment rate established by the Secretary that provides
12 for payments for such items and services to be based upon
13 a national rate adjusted to take into account the relative
14 costs of furnishing such items and services in various geo-
15 graphic areas, except that for items and services furnished
16 during cost reporting periods (or portions thereof) in years
17 beginning with 1996, such amount shall be equal to 95
18 percent of the amount that would otherwise have been de-
19 termined;”.

20 (b) ESTABLISHMENT OF PROSPECTIVE PAYMENT
21 SYSTEM.—Not later than July 1, 1995, the Secretary of
22 Health and Human Services shall establish the prospective
23 payment system for hospital outpatient services necessary
24 to carry out section 1833(a)(2)(B) of the Social Security
25 Act (as amended by subsection (a)).

1 (c) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to items and services furnished
3 on or after January 1, 1996.

4 **SEC. 15224. REDUCTION IN MEDICARE PAYMENTS TO HOS-**
5 **PITALS FOR INPATIENT CAPITAL-RELATED**
6 **COSTS.**

7 (a) PPS HOSPITALS.—Section 1886(g)(1)(A) (42
8 U.S.C. 1395ww(g)(1)(A)) is amended by striking “1995”
9 and inserting “1996”.

10 (b) REDUCTION IN BASE PAYMENT RATES FOR PPS
11 HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C.
12 1395ww(g)(1)(A)) is amended by adding at the end the
13 following new sentence: “In addition to the reduction de-
14 scribed in the preceding sentence, for discharges occurring
15 after September 30, 1995, the Secretary shall reduce by
16 7.47 percent the unadjusted standard Federal capital pay-
17 ment rate (as described in 42 CFR 412.308(c), as in effect
18 on the date of the enactment of the Omnibus Budget Rec-
19 onciliation Act of 1995) and shall reduce by 8.27 percent
20 the unadjusted hospital-specific rate (as described in 42
21 CFR 412.328(e)(1), as in effect on the date of the enact-
22 ment of the Omnibus Budget Reconciliation Act of
23 1995).”.

1 (c) PPS-EXEMPT HOSPITALS.—Section 1861(v)(1)
 2 (42 U.S.C. 1395x(v)(1)) is amended by adding at the end
 3 the following:

4 “(T) Such regulations shall provide that,
 5 in determining the amount of the payments
 6 that may be made under this title with respect
 7 to the capital-related costs of inpatient hospital
 8 services furnished by a hospital that is not a
 9 subsection (d) hospital (as defined in section
 10 1886(d)(1)(B)) or a subsection (d) Puerto Rico
 11 hospital (as defined in section 1886(d)(9)(A)),
 12 the Secretary shall reduce the amounts of such
 13 payments otherwise established under this title
 14 by 10 percent for payments attributable to por-
 15 tions of cost reporting periods occurring during
 16 fiscal year 1996.”.

17 **SEC. 15225. MORATORIUM ON PPS EXEMPTION FOR LONG-**
 18 **TERM CARE HOSPITALS.**

19 (a) IN GENERAL.—Section 1886(d)(1)(B)(iv) (42
 20 U.S.C. 1395ww(d)(1)(B)(iv)) is amended by striking
 21 “Secretary)” and inserting “Secretary on or before Sep-
 22 tember 30, 1995)”.

23 (b) RECOMMENDATIONS ON APPROPRIATE STAND-
 24 ARDS FOR LONG-TERM CARE HOSPITALS.—Not later
 25 than 1 year after the date of the enactment of this Act,

1 the Secretary of Health and Human Services shall submit
 2 to Congress recommendations for modifications to the
 3 standards used by the Secretary to determine whether a
 4 hospital (including a distinct part of another hospital) is
 5 classified as a long-term care hospital for purposes of de-
 6 termining the amount of payment to the hospital under
 7 part A of the medicare program for the operating costs
 8 of inpatient hospital services.

9 **SEC. 15226. ELIMINATION OF CERTAIN ADDITIONAL PAY-**
 10 **MENTS FOR OUTLIER CASES.**

11 (a) **INDIRECT MEDICAL EDUCATION.**—Section
 12 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is
 13 amended—

14 (1) by striking “the sum of”; and

15 (2) by striking “and the amount paid to the
 16 hospital under subparagraph (A)”.

17 (b) **DISPROPORTIONATE SHARE ADJUSTMENTS.**—
 18 Section 1886(d)(5)(F)(ii)(I) (42 U.S.C.
 19 1395ww(d)(5)(F)(ii)(I)) is amended—

20 (1) by striking “the sum of”; and

21 (2) by striking “and the amount paid to the
 22 hospital under subparagraph (A) for that dis-
 23 charge”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to discharges occurring on or after
3 October 1, 1995.

4 **PART 4—PROVISIONS AFFECTING OTHER**
5 **PROVIDERS.**

6 **SEC. 15231. REVISION OF PAYMENT METHODOLOGY FOR**
7 **HOME HEALTH SERVICES.**

8 (a) ADDITIONS TO COST LIMITS.—Section
9 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by
10 adding at the end the following new clauses:

11 “(iv) For services furnished by home
12 health agencies for cost reporting periods
13 beginning on or after October 1, 1996, the
14 Secretary shall provide for an interim sys-
15 tem of limits. Payment shall be the lower
16 of—

17 “(I) costs determined under the
18 preceding provisions of this subpara-
19 graph, or

20 “(II) an agency-specific per bene-
21 ficiary annual limit calculated from
22 the agency’s 12-month cost reporting
23 period ending on or after January 1,
24 1994 and on or before December 31,
25 1994 based on reasonable costs (in-

1 cluding non-routine medical supplies),
 2 updated by the home health market
 3 basket index. The per beneficiary limi-
 4 tation shall be multiplied by the agen-
 5 cy's unduplicated census count of
 6 Medicare patients for the year subject
 7 to the limitation. The limitation shall
 8 represent total Medicare reasonable
 9 costs divided by the unduplicated cen-
 10 sus count of Medicare patients.

11 “(v) For services furnished by home
 12 health agencies for cost reporting periods
 13 beginning on or after October 1, 1996, the
 14 following rules shall apply:

15 “(I) For new providers and those
 16 providers without a 12-month cost re-
 17 porting period ending in calendar year
 18 1994, the per beneficiary limit shall
 19 be equal to the mean of these limits
 20 (or the Secretary's best estimates
 21 thereof) applied to home health agen-
 22 cies as determined by the Secretary.
 23 Home health agencies that have al-
 24 tered their corporate structure or

1 name may not be considered new pro-
2 viders for payment purposes.

3 “(II) For beneficiaries who use
4 services furnished by more than one
5 home health agency, the per bene-
6 ficiary limitation shall be pro-rated
7 among agencies.

8 “(vi) Home health agencies whose cost
9 or utilization experience is below 125 per-
10 cent of the mean national or census region
11 aggregate per beneficiary cost or utilization
12 experience for 1994, or best estimates
13 thereof, and whose year-end reasonable
14 costs are below the agency-specific per ben-
15 eficiary limit, shall receive payment equal
16 to 50 percent of the difference between the
17 agency’s reasonable costs and its limit for
18 fiscal years 1996, 1997, 1998, and 1999.
19 Such payments may not exceed 5 percent
20 of an agency’s aggregate Medicare reason-
21 able cost in a year.

22 “(vii) Effective January 1, 1997, or
23 as soon as feasible, the Secretary shall
24 modify the agency specific per beneficiary
25 annual limit described in clause (iv) to pro-

1 vide for regional or national variations in
2 utilization. For purposes of determining
3 payment under clause (iv), the limit shall
4 be calculated through a blend of 75 per-
5 cent of the agency-specific cost or utiliza-
6 tion experience in 1994 with 25 percent of
7 the national or census region cost or utili-
8 zation experience in 1994, or the Sec-
9 retary's best estimates thereof."

10 (b) USE OF INTERIM FINAL REGULATIONS.—The
11 Secretary shall implement the payment limits described in
12 section 1861(v)(1)(L)(iv) of the Social Security Act by
13 publishing in the Federal Register a notice of interim final
14 payment limits by August 1, 1996 and allowing for a pe-
15 riod of public comments thereon. Payments subject to
16 these limits will be effective for cost reporting periods be-
17 ginning on or after October 1, 1996, without the necessity
18 for consideration of comments received, but the Secretary
19 shall, by Federal Register notice, affirm or modify the lim-
20 its after considering those comments.

21 (c) STUDIES.—The Secretary shall expand research
22 on a prospective payment system for home health agencies
23 that shall tie prospective payments to an episode of care,
24 including an intensive effort to develop a reliable case mix
25 adjuster that explains a significant amount of the

1 variances in costs. The Secretary shall develop such a sys-
2 tem for implementation in fiscal year 2000.

3 (d) PAYMENTS DETERMINED ON PROSPECTIVE
4 BASIS.—Title XVIII is amended by adding at the end the
5 following new section:

6 “PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

7 “SEC. 1893. (a) Notwithstanding section 1861(v),
8 the Secretary shall, for cost reporting periods beginning
9 on or after fiscal year 2000, provide for payments for
10 home health services in accordance with a prospective pay-
11 ment system, which pays home health agencies on a per
12 episode basis, established by the Secretary.

13 “(b) Such a system shall include the following:

14 “(1) Per episode rates under the system shall
15 be 15 percent less than those that would otherwise
16 occur under fiscal year 2000 Medicare expenditures
17 for home health services.

18 “(2) All services covered and paid on a reason-
19 able cost basis under the Medicare home health ben-
20 efit as of the date of the enactment of the Medicare
21 Enhancement Act of 1995, including medical sup-
22 plies, shall be subject to the per episode amount. In
23 defining an episode of care, the Secretary shall con-
24 sider an appropriate length of time for an episode
25 the use of services and the number of visits provided
26 within an episode, potential changes in the mix of

1 services provided within an episode and their cost,
 2 and a general system design that will provide for
 3 continued access to quality services. The per episode
 4 amount shall be based on the most current audited
 5 cost report data available to the Secretary.

6 “(c) The Secretary shall employ an appropriate case
 7 mix adjuster that explains a significant amount of the var-
 8 iation in cost.

9 “(d) The episode payment amount shall be adjusted
 10 annually by the home health market basket index. The
 11 labor portion of the episode amount shall be adjusted for
 12 geographic differences in labor-related costs based on the
 13 most current hospital wage index.

14 “(e) The Secretary may designate a payment provi-
 15 sion for outliers, recognizing the need to adjust payments
 16 due to unusual variations in the type or amount of medi-
 17 cally necessary care.

18 “(f) A home health agency shall be responsible for
 19 coordinating all care for a beneficiary. If a beneficiary
 20 elects to transfer to, or receive services from, another
 21 home health agency within an episode period, the episode
 22 payment shall be pro-rated between home health agen-
 23 cies.”.

1 SEC. 15232. LIMITATION OF HOME HEALTH COVERAGE

2 UNDER PART A.

3 (a) IN GENERAL.—Section 1812(a)(3) (42 U.S.C.
4 1395d(a)(3)) is amended by striking the semicolon and in-
5 serting “for up to 150 days during any spell of illness;”.

6 (b) CONFORMING AMENDMENT.—Section 1812(b)
7 (42 U.S.C. 1395d(b)) is amended—

8 (1) by striking “or” at the end of paragraph

9 (2),

10 (2) by striking the period at the end of para-
11 graph (3) and inserting “; or”, and

12 (3) by adding at the end the following new
13 paragraph:

14 “(4) home health services furnished to the indi-
15 vidual during such spell after such services have
16 been furnished to the individual for 150 days during
17 such spell.”.

18 (3) EXCLUSION OF ADDITIONAL PART B COSTS
19 FROM DETERMINATION OF PART B MONTHLY PRE-
20 MIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is
21 amended—

22 (A) in the second sentence of paragraph

23 (1), by striking “enrollees.” and inserting “en-
24 rollees (except as provided in paragraph (5)).”;

25 and

1 (B) by adding at the end the following new
2 paragraph:

3 “(5) In estimating the benefits and administrative
4 costs which will be payable from the Federal Supple-
5 mentary Medical Insurance Trust Fund for a year (begin-
6 ning with 1996), the Secretary shall exclude an estimate
7 of any benefits and costs attributable to home health serv-
8 ices for which payment would have been made under part
9 A during the year but for paragraph (4) of section
10 1812(b).”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this subsection shall apply to spells of illness beginning
13 on or after October 1, 1995.

14 **SEC. 15233. REDUCTION IN FEE SCHEDULE FOR DURABLE**
15 **MEDICAL EQUIPMENT.**

16 (a) IN GENERAL.—

17 (1) FREEZE IN UPDATE FOR COVERED
18 ITEMS.—Section 1834(a)(14) (42 U.S.C.
19 1395m(a)(14)) is amended—

20 (A) by striking “and” at the end of sub-
21 paragraph (A);

22 (B) in subparagraph (B)—

23 (i) by striking “a subsequent year”
24 and inserting “1993, 1994, and 1995”,
25 and

1 (ii) by striking the period at the end
2 and inserting “; and”; and

3 (C) by adding at the end the following:

4 “(C) for each of the years 1996 through
5 1998, 0 percent; and

6 “(D) for a subsequent year, the percentage
7 increase in the consumer price index for all
8 urban consumers (U.S. urban average) for the
9 12-month period ending with June of the pre-
10 vious year.”.

11 (2) UPDATE FOR ORTHOTICS AND PROSTHET-
12 ICS.—Section 1834(h)(4)(A)(iii) (42 U.S.C.
13 1395m(h)(4)(A)(iii)) is amended by striking “1994
14 and 1995” and inserting “each of the years 1994
15 through 1998”.

16 (b) OXYGEN AND OXYGEN EQUIPMENT.—Section
17 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

18 (1) by striking “and” at the end of clause (iii);

19 (2) in clause (iv)—

20 (A) by striking “a subsequent year” and
21 inserting “1993, 1994, and 1995”, and

22 (B) by striking the period at the end and
23 inserting “; and”; and

24 (3) by adding at the end the following new
25 clause:

1 “(v) in 1996 and each subsequent
2 year, is 90 percent of the national limited
3 monthly payment rate computed under
4 subparagraph (B) for the item for the
5 year.”.

6 **SEC. 15234. NURSING HOME BILLING.**

7 (a) **PAYMENTS FOR ROUTINE SERVICE COSTS.—**

8 (1) **CLARIFICATION OF DEFINITION OF ROU-**
9 **TINE SERVICE COSTS.—**Section 1888 (42 U.S.C.
10 1395yy) is amended by adding at the end the follow-
11 ing new subsection:

12 “(e) For purposes of this section, the ‘routine service
13 costs’ of a skilled nursing facility are all costs which are
14 attributable to nursing services, room and board, adminis-
15 trative costs, other overhead costs, and all other ancillary
16 services (including supplies and equipment), excluding
17 costs attributable to covered non-routine services subject
18 to payment limits under section 1888A.”.

19 (2) **CONFORMING AMENDMENT.—**Section 1888
20 (42 U.S.C. 1395yy) is amended in the heading by
21 inserting “AND CERTAIN ANCILLARY” after “SERV-
22 ICE”.

23 (b) **INCENTIVES FOR COST-EFFECTIVE MANAGE-**
24 **MENT OF COVERED NON-ROUTINE SERVICES.—**

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

“INCENTIVES FOR COST-EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES

“SEC. 1888A. (a) DEFINITIONS.—For purposes of this section:

“(1) COVERED NON-ROUTINE SERVICES.—The term ‘covered non-routine services’ means post-hospital extended care services consisting of any of the following:

“(A) Physical or occupational therapy or speech-language pathology services, or respiratory therapy.

“(B) Prescription drugs.

“(C) Complex medical equipment.

“(D) Intravenous therapy and solutions (including enteral and parenteral nutrients, supplies, and equipment).

“(E) Radiation therapy.

“(F) Diagnostic services, including laboratory, radiology (including computerized tomography services and imaging services), and pulmonary services.

1 “(2) SNF MARKET BASKET PERCENTAGE IN-
2 CREASE.—The term ‘SNF’ market basket percentage
3 increase’ for a fiscal year means a percentage equal
4 to the percentage increase in routine service cost
5 limits for the year under section 1888(a).

6 “(3) STAY.—The term ‘stay’ means, with re-
7 spect to an individual who is a resident of a skilled
8 nursing facility, a period of continuous days during
9 which the facility provides extended care services for
10 which payment may be made under this title to the
11 individual during the individual’s spell of illness.

12 “(b) NEW PAYMENT METHOD FOR COVERED NON-
13 ROUTINE SERVICES.—

14 “(1) IN GENERAL.—Subject to subsection (c), a
15 skilled nursing facility shall receive interim pay-
16 ments under this title for covered non-routine serv-
17 ices furnished to an individual during a cost report-
18 ing period beginning during a fiscal year (after fiscal
19 year 1996) in an amount equal to the reasonable
20 cost of providing such services in accordance with
21 section 1861(v). The Secretary may adjust such pay-
22 ments if the Secretary determines (on the basis of
23 such estimated information as the Secretary consid-
24 ers appropriate) that payments to the facility under
25 this paragraph for a cost reporting period would

substantially exceed the cost reporting period limit determined under subsection (c)(1)(B).

“(2) RESPONSIBILITY OF SKILLED NURSING FACILITY TO MANAGE BILLINGS.—

“(A) CLARIFICATION RELATING TO PART A BILLING.—In the case of a covered non-routine service furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is entitled to coverage under section 1812(a)(2) for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part A (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

“(B) PART B BILLING.—In the case of a covered non-routine service furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is not entitled to coverage under section 1812(a)(2) for such service but is entitled to coverage under part B for such service, the skilled nursing facility shall submit a claim for

1 payment under this title for such service under
 2 part B (without regard to whether or not the
 3 item or service was furnished by the facility, by
 4 others under arrangement with them made by
 5 the facility, under any other contracting or con-
 6 sulting arrangement, or otherwise).

7 “(C) MAINTAINING RECORDS ON SERVICES
 8 FURNISHED TO RESIDENTS.—Each skilled nurs-
 9 ing facility receiving payments for extended
 10 care services under this title shall document on
 11 the facility’s cost report all covered non-routine
 12 services furnished to all residents of the facility
 13 to whom the facility provided extended care
 14 services for which payment was made under
 15 part A during a fiscal year (beginning with fis-
 16 cal year 1996) (without regard to whether or
 17 not the services were furnished by the facility,
 18 by others under arrangement with them made
 19 by the facility, under any other contracting or
 20 consulting arrangement, or otherwise).

21 “(c) RECONCILIATION OF AMOUNTS.—

22 “(1) LIMIT BASED ON PER STAY LIMIT AND
 23 NUMBER OF STAYS.—

24 “(A) IN GENERAL.—If a skilled nursing fa-
 25 cility has received aggregate payments under

subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in excess of an amount equal to the cost reporting period limit determined under subparagraph (B), the Secretary shall reduce the payments made to the facility with respect to such services for cost reporting periods beginning during the following fiscal year in an amount equal to such excess. The Secretary shall reduce payments under this subparagraph at such times and in such manner during a fiscal year as the Secretary finds necessary to meet the requirement of this subparagraph.

“(B) COST REPORTING PERIOD LIMIT.—

The cost reporting period limit determined under this subparagraph is an amount equal to the product of—

“(i) the per stay limit applicable to the facility under subsection (d) for the period; and

“(ii) the number of stays beginning during the period for which payment was made to the facility for such services.

“(C) PROSPECTIVE REDUCTION IN PAYMENTS.—In addition to the process for reduc-

1 ing payments described in subparagraph (A),
 2 the Secretary may reduce payments made to a
 3 facility under this section during a cost report-
 4 ing period if the Secretary determines (on the
 5 basis of such estimated information as the Sec-
 6 retary considers appropriate) that payments to
 7 the facility under this section for the period will
 8 substantially exceed the cost reporting period
 9 limit for the period determined under this para-
 10 graph.

11 “(2) INCENTIVE PAYMENTS.—

12 “(A) IN GENERAL.—If a skilled nursing fa-
 13 cility has received aggregate payments under
 14 subsection (b) for covered non-routine services
 15 during a cost reporting period beginning during
 16 a fiscal year in an amount that is less than the
 17 amount determined under paragraph (1)(B),
 18 the Secretary shall pay the skilled nursing facil-
 19 ity in the following fiscal year an incentive pay-
 20 ment equal to 50 percent of the difference be-
 21 tween such amounts, except that the incentive
 22 payment may not exceed 5 percent of the aggre-
 23 gate payments made to the facility under sub-
 24 section (b) for the previous fiscal year (without
 25 regard to subparagraph (B)).

“(B) INSTALLMENT INCENTIVE PAYMENTS.—The Secretary may make installment payments during a fiscal year to a skilled nursing facility based on the estimated incentive payment that the facility would be eligible to receive with respect to such fiscal year.

“(d) DETERMINATION OF FACILITY PER STAY LIMIT.—

“(1) LIMIT FOR FISCAL YEAR 1997.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall establish separate per stay limits for hospital-based and freestanding skilled nursing facilities for the 12-month cost reporting period beginning during fiscal year 1997 that are equal to the sum of—

“(i) 50 percent of the facility-specific stay amount for the facility (as determined under subsection (e)) for the last 12-month cost reporting period ending on or before September 30, 1994, increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997; and

“(ii) 50 percent of the average of all facility-specific stay amounts for all hos-

1 pital-based facilities or all freestanding fa-
 2 cilities (whichever is applicable) during the
 3 cost reporting period described in clause
 4 (i), increased (in a compounded manner)
 5 by the SNF market basket percentage in-
 6 crease for fiscal years 1995 through 1997.

7 “(B) FACILITIES NOT HAVING 1994 COST
 8 REPORTING PERIOD.—In the case of a skilled
 9 nursing facility for which payments were not
 10 made under this title for covered non-routine
 11 services for the last 12-month cost reporting pe-
 12 riod ending on or before September 30, 1994,
 13 the per stay limit for the 12-month cost report-
 14 ing period beginning during fiscal year 1997
 15 shall be twice the amount determined under
 16 subparagraph (A)(ii).

17 “(2) LIMIT FOR SUBSEQUENT FISCAL YEARS.—
 18 The per stay limit for a skilled nursing facility for
 19 a 12-month cost reporting period beginning during
 20 a fiscal year after fiscal year 1997 is equal to the
 21 per stay limit established under this subsection for
 22 the 12-month cost reporting period beginning during
 23 the previous fiscal year, increased by the SNF mar-
 24 ket basket percentage increase for such subsequent
 25 fiscal year minus 2 percentage points.

“(3) REBASING OF AMOUNTS.—

“(A) IN GENERAL.—The Secretary shall provide for an update to the facility-specific amounts used to determine the per stay limits under this subsection for cost reporting periods beginning on or after October 1, 1999, and every 2 years thereafter.

“(B) TREATMENT OF FACILITIES NOT HAVING REBASED COST REPORTING PERIODS.—

Paragraph (1)(B) shall apply with respect to a skilled nursing facility for which payments were not made under this title for covered non-routine services for the 12-month cost reporting period used by the Secretary to update facility-specific amounts under subparagraph (A) in the same manner as such paragraph applies with respect to a facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994.

“(e) DETERMINATION OF FACILITY-SPECIFIC STAY AMOUNTS.—The ‘facility-specific stay amount’ for a skilled nursing facility for a cost reporting period is the sum of—

1 “(1) the average amount of payments made to
2 the facility under part A during the period which are
3 attributable to, covered non-routine services fur-
4 nished during a stay (as determined on a per diem
5 basis); and

6 “(2) the Secretary’s best estimate of the aver-
7 age amount of payments made under part B during
8 the period for covered non-routine services furnished
9 to all residents of the facility to whom the facility
10 provided extended care services for which payment
11 was made under part A during the period (without
12 regard to whether or not the services were furnished
13 by the facility, by others under arrangement with
14 them made by the facility, under any other contract-
15 ing or consulting arrangement, or otherwise), as es-
16 timated by the Secretary.

17 “(f) INTENSIVE NURSING OR THERAPY NEEDS.—

18 “(1) IN GENERAL.—In applying subsection (b)
19 to covered non-routine services furnished during a
20 stay beginning during a cost reporting period begin-
21 ning during a fiscal year (beginning with fiscal years
22 after fiscal year 1997) to a resident of a skilled
23 nursing facility who requires intensive nursing or
24 therapy services, the per stay limit for such resident
25 shall be the per stay limit developed under para-

graph (2) instead of the per stay limit determined under subsection (d)(1)(A).

“(2) PER STAY LIMIT FOR INTENSIVE NEED RESIDENTS.—Not later than June 30, 1997, the Secretary, after consultation with the Medicare Payment Review Commission and skilled nursing facility experts, shall develop and publish a per stay limit for residents of a skilled nursing facility who require intensive nursing or therapy services.

“(3) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

“(g) SPECIAL TREATMENT FOR SMALL SKILLED NURSING FACILITIES.—This section shall not apply with respect to a skilled nursing facility for which payment is made for routine service costs during a cost reporting period on the basis of prospective payments under section 1888(d).

“(h) EXCEPTIONS AND ADJUSTMENTS TO LIMITS.—

“(1) IN GENERAL.—The Secretary may make exceptions and adjustments to the cost reporting

1 limits applicable to a skilled nursing facility under
 2 subsection (c)(1)(B) for a cost reporting period, ex-
 3 cept that the total amount of any additional pay-
 4 ments made under this section for covered non-rou-
 5 tine services during the cost reporting period as a
 6 result of such exceptions and adjustments may not
 7 exceed 5 percent of the aggregate payments made to
 8 all skilled nursing facilities for covered non-routine
 9 services during the cost reporting period (determined
 10 without regard to this paragraph).

11 “(2) BUDGET NEUTRALITY.—The Secretary
 12 shall adjust payments under subsection (b) in a
 13 manner that ensures that total payments for covered
 14 non-routine services under this section are not great-
 15 er or less than total payments for such services
 16 would have been but for the application of para-
 17 graph (1).

18 “(i) SPECIAL RULE FOR X-RAY SERVICES.—Before
 19 furnishing a covered non-routine service consisting of an
 20 X-ray service for which payment may be made under part
 21 A or part B to a resident, a skilled nursing facility shall
 22 consider whether furnishing the service through a provider
 23 of portable X-ray service services would be appropriate,
 24 taking into account the cost effectiveness of the service
 25 and the convenience to the resident.”.

(2) CONFORMING AMENDMENT.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking “1813 and 1886” and inserting “1813, 1886, 1888, and 1888A”.

SEC. 15235. FREEZE IN PAYMENTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended by striking “1994 and 1995” and inserting “1994 through 1998”.

PART 5—GRADUATE MEDICAL EDUCATION AND TEACHING HOSPITALS

SEC. 15241. TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.

(a) TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.—The Social Security Act (42 U.S.C. 300 et seq.) is amended by adding at the end the following title:

“TITLE XXI—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

“PART A—ESTABLISHMENT OF FUND

“SEC. 2101. ESTABLISHMENT OF FUND.

“(a) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the Teaching Hospital and Graduate Medical Education Trust

1 Fund (in this title referred to as the 'Fund'), consisting
 2 of amounts transferred to the Fund under subsection (c),
 3 amounts appropriated to the Fund pursuant to sub-
 4 sections (d) and (e)(3), and such gifts and bequests as
 5 may be deposited in the Fund pursuant to subsection (f).
 6 Amounts in the Fund are available until expended.

7 “(b) EXPENDITURES FROM FUND.—Amounts in the
 8 Fund are available to the Secretary for making payments
 9 under section 2111.

10 “(c) TRANSFERS TO FUND.—

11 “(1) IN GENERAL.—From the Federal Hospital
 12 Insurance Trust Fund and the Federal Supple-
 13 mentary Medical Insurance Trust Fund, the Sec-
 14 retary shall, for fiscal year 1996 and each subse-
 15 quent fiscal year, transfer to the Fund an amount
 16 determined by the Secretary for the fiscal year in-
 17 volved in accordance with paragraph (2).

18 “(2) DETERMINATION OF AMOUNTS.—For pur-
 19 poses of paragraph (1), the amount determined
 20 under this paragraph for a fiscal year is an estimate
 21 by the Secretary of an amount equal to 75 percent
 22 of the difference between—

23 “(A) the nationwide total of the amounts
 24 that would have been paid under sections 1855

and 1876 during the year but for the operation of section 1855(b)(2)(B)(ii); and

“(B) the nationwide total of the amounts paid under such sections during the year.

“(3) ALLOCATION BETWEEN MEDICARE TRUST FUNDS.—In providing for a transfer under paragraph (1) for a fiscal year, the Secretary shall provide for an allocation of the amounts involved between part A and part B of title XVIII (and the trust funds established under the respective parts) as reasonably reflects the proportion of payments for the indirect costs of medical education and direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

“(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Fund such sums as may be necessary for each of the fiscal years 1996 through 2002.

“(e) INVESTMENT.—

“(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund. Such investments may be made only in interest-bearing obliga-

tions of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

5 “(2) SALE OF OBLIGATIONS.—Any obligation
6 acquired by the Fund may be sold by the Secretary
7 of the Treasury at the market price.

8 “(3) AVAILABILITY OF INCOME.—Any interest
9 derived from obligations acquired by the Fund, and
10 proceeds from any sale or redemption of such obliga-
11 tions, are hereby appropriated to the Fund.

“(f) ACCEPTANCE OF GIFTS AND BEQUESTS.—The Fund may accept on behalf of the United States money gifts and bequests made unconditionally to the Fund for the benefit of the Fund or any activity financed through the Fund.

17 "PART B—PAYMENTS TO TEACHING HOSPITALS
18 "SEC. 2111. FORMULA PAYMENTS TO TEACHING HOS-
19 PITALS.

20 “(a) IN GENERAL.—In the case of each teaching hos-
21 pital that in accordance with subsection (b) submits to the
22 Secretary a payment document for fiscal year 1996 or any
23 subsequent fiscal year, the Secretary shall make payments
24 for the year to the teaching hospital for the direct and
25 indirect costs of operating approved medical residency

1 training programs. Such payments shall be made from the
2 Fund, and shall be made in accordance with a formula
3 established by the Secretary.

4 “(b) PAYMENT DOCUMENT.—For purposes of sub-
5 section (a), a payment document is a document containing
6 such information as may be necessary for the Secretary
7 to make payments under such subsection to a teaching
8 hospital for a fiscal year. The document is submitted in
9 accordance with this subsection if the document is submit-
10 ted not later than the date specified by the Secretary, and
11 the document is in such form and is made in such manner
12 as the Secretary may require. The Secretary may require
13 that information under this subsection be submitted to the
14 Secretary in periodic reports.”.

15 (b) NATIONAL ADVISORY COUNCIL ON POST-
16 GRADUATE MEDICAL EDUCATION.—

17 (1) IN GENERAL.—There is established within
18 the Department of Health and Human Services an
19 advisory council to be known as the National Advi-
20 sory Council on Postgraduate Medical Education (in
21 this title referred to as the “Council”).

22 (2) DUTIES.—The council shall provide advice
23 to the Secretary on appropriate policies for making
24 payments for the support of postgraduate medical
25 education in order to assure an adequate supply of

1 physicians trained in various specialities, consistent
2 with the health care needs of the United States.

3 (3) COMPOSITION.—

4 (A) IN GENERAL.—The Secretary shall ap-
5 point to the Council 15 individuals who are not
6 officers or employees of the United States. Such
7 individuals shall include not less than 1 individ-
8 ual from each of the following categories of in-
9 dividuals or entities:

10 (i) Organizations representing con-
11 sumers of health care services.

12 (ii) Physicians who are faculty mem-
13 bers of medical schools, or who supervise
14 approved physician training programs.

15 (iii) Physicians in private practice who
16 are not physicians described in clause (ii).

17 (iv) Practitioners in public health.

18 (v) Advanced-practice nurses.

19 (vi) Other health professionals who
20 are not physicians.

21 (vii) Medical schools.

22 (viii) Teaching hospitals.

23 (ix) The Accreditation Council on
24 Graduate Medical Education.

(x) The American Board of Medical Specialities.

(xi) The Council on Postdoctoral Training of the American Osteopathic Association.

(xii) The Council on Podiatric Medical Education of the American Podiatric Medical Association.

(B) REQUIREMENTS REGARDING REPRESENTATIVE MEMBERSHIP.—To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States, shall reflect the racial, ethnic, and gender composition of the population of the United States, and shall be broadly representative of medical schools and teaching hospitals in the United States.

(C) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary (or by other Federal officers who are appointed by the President with

1 the advice and consent of the Senate). Individ-
 2 uals designated under the preceding sentence
 3 shall include each of the following officials (or
 4 a designee of the official):

5 (i) The Secretary of Health and
 6 Human Services.

7 (ii) The Secretary of Veterans Affairs.

8 (iii) The Secretary of Defense.

9 (4) CHAIR.—The Secretary shall, from among
 10 members of the council appointed under paragraph
 11 (3)(A), designate an individual to serve as the chair
 12 of the council.

13 (5) TERMINATION.—The Council terminates
 14 December 31, 1999.

15 (c) REMOVE MEDICAL EDUCATION AND DISPROPOR-
 16 TIONATE SHARE HOSPITAL PAYMENTS FROM CALCULA-
 17 TION OF ADJUSTED AVERAGE PER CAPITA COST.—For
 18 provision removing medical education and disproportion-
 19 ate share hospital payments from calculation of payment
 20 amounts for organizations paid on a capitated basis, see
 21 section 1855(b)(2)(B)(ii).

22 (2) PAYMENTS TO HOSPITALS OF AMOUNTS AT-
 23 TRIBUTABLE TO DSH.—Section 1886 (42 U.S.C.
 24 1395ww) is amended by adding at the end the fol-
 25 lowing new subsection:

1 “(j)(1) In addition to amounts paid under subsection
2 (d)(5)(F), the Secretary is authorized to pay hospitals
3 which are eligible for such payments for a fiscal year sup-
4 plemental amounts that do not exceed the limit provided
5 for in paragraph (2).

6 “(2) The sum of the aggregate amounts paid pursu-
7 ant to paragraph (1) for a fiscal year shall not exceed the
8 Secretary’s estimate of 75 percent of the amount of reduc-
9 tions in payments under section 1855 that are attributable
10 to the operation of subsection (b)(2)(B)(ii) of such
11 section. ”.

12 **SEC. 15242. REDUCTION IN PAYMENT ADJUSTMENTS FOR**
13 **INDIRECT MEDICAL EDUCATION.**

14 (a) MODIFICATION REGARDING 5.6 PERCENT.—Sec-
15 tion 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is
16 amended—

17 (1) by striking “on or after October 1, 1988,”
18 and inserting “on or after October 1, 1999,”; and

19 (2) by striking “1.89” and inserting “1.38”.

20 (b) SPECIAL RULE REGARDING FISCAL YEARS 1996
21 THROUGH 1998; MODIFICATION REGARDING 6 PER-
22 CENT.—Section 1886(d)(5)(B)(ii), as amended by para-
23 graph (1), is amended by adding at the end the following:
24 “In the case of discharges occurring on or after October
25 1, 1995, and before October 1, 1999, the preceding sen-

1 tence applies to the same extent and in the same manner
2 as the sentence applies to discharges occurring on or after
3 October 1, 1999, except that the term ‘1.38’ is deemed
4 to be 1.48.”.

5 **Subtitle D—Provisions Relating to** 6 **Medicare Beneficiaries**

7 **SEC. 15301. EXTENDING MEDICARE PART B PREMIUM.**

8 Section 1839(e) (42 U.S.C. 1395r(e)) is amended—

9 (1) in paragraph (1)(A), by striking “January
10 1999 shall be an amount equal to 50 percent” and
11 inserting “January 2003 shall be an amount equal
12 to 56 percent”, and

13 (2) in paragraph (2) by striking “1998” and in-
14 serting “2002”.

15 **SEC. 15302. RELATING MEDICARE PART B PREMIUM TO IN-** 16 **COME FOR CERTAIN HIGH INCOME INDIVID-** 17 **UALS.**

18 (a) INCREASE IN PREMIUM.—

19 (1) IN GENERAL.—Section 1839 (42 U.S.C.
20 1395r) is amended by adding at the end the follow-
21 ing:

22 “(h)(1) Notwithstanding the previous subsections of
23 this section, in the case of an individual whose modified
24 adjusted gross income in a taxable year ending with or
25 within a calendar year (as reported by the individual under

1 section 1894(a)) is equal to or exceeds the sum of the
 2 threshold amount described in paragraph (4) and
 3 \$25,000, the amount of the monthly premium for the cal-
 4 endar year shall be increased by an amount such that the
 5 total monthly premium (determined without regard to sub-
 6 section (b)) is equal to 200 percent of the monthly actuar-
 7 ial rate for enrollees age 65 and over as determined under
 8 subsection (a)(1) for that calendar year. The preceding
 9 sentence shall not apply to any individual whose threshold
 10 amount is zero.

11 “(2) Notwithstanding the previous subsections of this
 12 section, in the case of an individual not described in para-
 13 graph (1) whose modified adjusted gross income in a tax-
 14 able year ending with or within a calendar year (as re-
 15 ported by the individual under section 1894(a)) exceeds
 16 the threshold amount described in paragraph (4), the
 17 amount of the monthly premium for the calendar year
 18 shall be increased by an amount which bears the same
 19 ratio to the amount of the increase determined under
 20 paragraph (1) as such excess bears to \$25,000. The pre-
 21 ceding sentence shall not apply to any individual whose
 22 threshold amount is zero.

23 “(3) Using information provided by the Secretary of
 24 the Treasury under section 6103(l)(14) of the Internal
 25 Revenue Code of 1986, the Secretary shall determine the

1 actual modified adjusted gross income of individuals en-
 2 rolled in this part during a taxable year and adjust the
 3 monthly premium applicable to an individual during a cal-
 4 endar year to take into account any overpayments or un-
 5 derpayments in the premium during the previous calendar
 6 year resulting from the application of this subsection.

7 “(4) In this subsection and section 1813(c), the term
 8 ‘threshold amount’ means—

9 “(A) except as otherwise provided in this para-
 10 graph, \$75,000,

11 “(B) \$100,000 in the case of an individual who
 12 files a joint return under section 6013 of the Inter-
 13 nal Revenue Code of 1986, and

14 “(C) zero in the case of an individual who—

15 “(i) is married at the close of the taxable
 16 year (as determined under section 7703 of the
 17 Internal Revenue Code of 1986) but does not
 18 file a joint return for such year, and

19 “(ii) does not live apart from the individ-
 20 ual’s spouse at all times during the taxable
 21 year.”.

22 (2) CONFORMING AMENDMENT.—Section
 23 1839(f) (42 U.S.C. 1395r(f)) is amended by striking
 24 “if an individual” and inserting the following: “if an
 25 individual (other than an individual subject to an in-

crease in the monthly premium under this section pursuant to subsection (h))”.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning after February 1996 in taxable years beginning after December 31, 1995.

(b) REPORTING REQUIREMENT FOR BENEFICIARIES.—Title XVIII, as amended by section 15231(d), is further amended by adding at the end the following:

“REPORT TO SECRETARY ON ESTIMATED MODIFIED
ADJUSTED GROSS INCOME

“SEC. 1894. (a) IN GENERAL.—

“(1) INDIVIDUALS COVERED THROUGHOUT YEAR.—Not later than November 1 of each year (beginning with 1996), each individual enrolled under part B shall submit to the Secretary (in such form and manner as the Secretary may require, in consultation with the Secretary of the Treasury) an estimate of the individual’s modified adjusted gross income anticipated for the taxable year ending with or within the following calendar year, to be used (subject to section 1839(h)(3)) to determine whether the individual is to be subject to an increase in the

1 monthly part B premium under section 1839(h) for
2 such following calendar year.

3 “(2) SPECIAL RULE FOR FIRST YEAR OF COV-
4 ERAGE.—For the first year in which an individual is
5 enrolled under part B, the individual shall submit to
6 the Secretary (at such time and in such form and
7 manner as the Secretary may require, in consulta-
8 tion with the Secretary of the Treasury) an estimate
9 of the individual’s modified adjusted gross income
10 anticipated for the taxable year ending with Decem-
11 ber 31 of such year, to be used to determine whether
12 the individual is to be subject to an increase in the
13 monthly part B premium under section 1839(h) for
14 such year.

15 “(b) SPECIAL RULE FOR 1996.—Not later than 60
16 days after the date of the enactment of this section, each
17 individual described in subsection (a) shall submit to the
18 Secretary an estimate of the individual’s modified adjusted
19 gross income for the taxable year ending December 1995,
20 to be used to determine (subject to section 1839(h)(3))
21 whether the individual is to be subject to an increase in
22 the monthly part B premium under section 1839(h) dur-
23 ing 1996.

24 “(c) MODIFIED ADJUSTED GROSS INCOME DE-
25 FINED.—In subsection (a), the term ‘modified adjusted

1 gross income' means, with respect to an individual for a
2 taxable year, the individual's adjusted gross income under
3 the Internal Revenue Code of 1986, determined without
4 regard to sections 931 or 933 of such Code."

5 (c) DISCLOSURE OF CERTAIN TAX INFORMATION BY
6 SECRETARY OF TREASURY.—

7 (1) IN GENERAL.—Subsection (l) of section
8 6103 of the Internal Revenue Code of 1986 (relating
9 to confidentiality and disclosure of returns and re-
10 turn information) is amended by adding at the end
11 thereof the following new paragraph:

12 "(14) DISCLOSURE OF RETURN INFORMATION
13 TO MEANS-TEST MEDICARE.—

14 "(A) IN GENERAL.—The Secretary shall,
15 upon written request from the Administrator of
16 the Health Care Financing Administration, dis-
17 close to the officers and employees of such Ad-
18 ministration return information necessary to
19 determine the modified adjusted gross income
20 (as defined in section 1894(c) of the Social Se-
21 curity Act) of any medicare beneficiary (as de-
22 fined in paragraph (12)(E)), to be used to de-
23 termine whether the beneficiary is to be subject
24 to an increase in the monthly part B premium
25 under section 1839(g) of such Act.

1 “(B) RESTRICTION ON USE OF DISCLOSED
2 INFORMATION.—Any officer or employee of the
3 Health Care Financing Administration receiv-
4 ing return information under subparagraph (A)
5 shall use such information only for purposes of,
6 and to the extent necessary in, establishing the
7 modified adjusted gross income (as so defined)
8 of any medicare beneficiary (as so defined).”

9 (2) CONFORMING AMENDMENTS.—Paragraphs
10 (3)(A) and (4) of section 6103(p) of such Code are
11 each amended by striking “or (13)” each place it ap-
12 pears and inserting “(13), or (14)”.

13 (3) EFFECTIVE DATE.—The amendments made
14 by paragraphs (1) and (2) shall apply with respect
15 to information for taxable years beginning after De-
16 cember 31, 1995.

17 **SEC. 15303. EXPANDED COVERAGE OF PREVENTIVE BENE-**
18 **FITS.**

19 (a) PROVIDING ANNUAL SCREENING MAMMOGRAPHY
20 FOR WOMEN OVER AGE 49.—Section 1834(c)(2)(A) (42
21 U.S.C. 1395m(c)(2)(A)) is amended—

22 (1) in clause (iv), by striking “but under 65
23 years of age,”; and

24 (2) by striking clause (v).

1 (b) COVERAGE OF SCREENING PAP SMEAR AND PEL-
2 VIC EXAMS.—

3 (1) COVERAGE OF PELVIC EXAM; INCREASING
4 FREQUENCY OF COVERAGE OF PAP SMEAR.—Section
5 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

6 (A) in the heading, by striking “Smear”
7 and inserting “Smear; Screening Pelvic Exam”;

8 (B) by striking “(nn)” and inserting
9 “(nn)(1)”;

10 (C) by striking “3 years” and all that fol-
11 lows and inserting “3 years, or during the pre-
12 ceding year in the case of a woman described
13 in paragraph (3).”; and

14 (D) by adding at the end the following new
15 paragraphs:

16 “(2) The term ‘screening pelvic exam’ means an pel-
17 vic examination provided to a woman if the woman in-
18 volved has not had such an examination during the preced-
19 ing 3 years, or during the preceding year in the case of
20 a woman described in paragraph (3), and includes a clini-
21 cal breast examination.

22 “(3) A woman described in this paragraph is a
23 woman who—

24 “(A) is of childbearing age and has not had a
25 test described in this subsection during each of the

1 preceding 3 years that did not indicate the presence
2 of cervical cancer; or

3 “(B) is at high risk of developing cervical can-
4 cer (as determined pursuant to factors identified by
5 the Secretary).”.

6 (2) WAIVER OF DEDUCTIBLE.—The first sen-
7 tence of section 1833(b) (42 U.S.C. 1395l(b)), as
8 amended by subsection (a)(2), is amended—

9 (A) by striking “and (5)” and inserting
10 “(5)”; and

11 (B) by striking the period at the end and
12 inserting the following: “, and (6) such deduct-
13 ible shall not apply with respect to screening
14 pap smear and screening pelvic exam (as de-
15 scribed in section 1861(nn)).”.

16 (3) CONFORMING AMENDMENTS.—(A) Section
17 1861(s)(14) (42 U.S.C. 1395x(s)(14)) is amended
18 by inserting “and screening pelvic exam” after
19 “screening pap smear”.

20 (B) Section 1862(a)(1)(F) (42 U.S.C.
21 1395y(a)(1)(F)) is amended by inserting “and
22 screening pelvic exam” after “screening pap smear”.

23 (c) COVERAGE OF COLORECTAL SCREENING.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

“(d) FREQUENCY AND PAYMENT LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS, SCREENING FLEXIBLE SIGMOIDOSCOPIES, AND SCREENING COLONOSCOPY.—

“(1) FREQUENCY LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening fecal-occult blood test provided to an individual for the purpose of early detection of colon cancer if the test is performed—

“(A) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph; or

“(B) in the case of any other individual, within the 11 months following the month in which a previous screening fecal-occult blood test was performed.

“(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

1 “(A) PAYMENT AMOUNT.—The Secretary
2 shall establish a payment amount under section
3 1848 with respect to screening flexible
4 sigmoidoscopies provided for the purpose of
5 early detection of colon cancer that is consistent
6 with payment amounts under such section for
7 similar or related services, except that such
8 payment amount shall be established without
9 regard to subsection (a)(2)(A) of such section.

10 “(B) FREQUENCY LIMITS.—Subject to re-
11 vision by the Secretary under paragraph (4), no
12 payment may be made under this part for a
13 screening flexible sigmoidoscopy provided to an
14 individual for the purpose of early detection of
15 colon cancer if the procedure is performed—

16 “(i) in the case of an individual under
17 65 years of age, more frequently than is
18 provided in a periodicity schedule estab-
19 lished by the Secretary for purposes of this
20 subparagraph; or

21 “(ii) in the case of any other individ-
22 ual, within the 59 months following the
23 month in which a previous screening flexi-
24 ble sigmoidoscopy was performed.

“(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

“(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening colonoscopy for individuals at high risk for colorectal cancer (as determined in accordance with criteria established by the Secretary) provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

“(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening colonoscopy for individuals at high risk for colorectal cancer provided to an individual for the purpose of early detection of colon cancer if the procedure is performed within the 47 months following the month in which a previous screening colonoscopy was performed.

“(C) FACTORS CONSIDERED IN ESTABLISHING CRITERIA FOR DETERMINING INDIVID-

1 UALS AT HIGH RISK.—In establishing criteria
 2 for determining whether an individual is at high
 3 risk for colorectal cancer for purposes of this
 4 paragraph, the Secretary shall take into consid-
 5 eration family history, prior experience of can-
 6 cer, a history of chronic digestive disease condi-
 7 tion, and the presence of any appropriate recog-
 8 nized gene markers for colorectal cancer.

9 “(4) REVISION OF FREQUENCY.—

10 “(A) REVIEW.—The Secretary shall review
 11 periodically the appropriate frequency for per-
 12 forming screening fecal-occult blood tests,
 13 screening flexible sigmoidoscopies, and screen-
 14 ing colonoscopy based on age and such other
 15 factors as the Secretary believes to be pertinent.

16 “(B) REVISION OF FREQUENCY.—The Sec-
 17 retary, taking into consideration the review
 18 made under clause (i), may revise from time to
 19 time the frequency with which such tests and
 20 procedures may be paid for under this sub-
 21 section.”.

22 (2) CONFORMING AMENDMENTS.—(A) Para-
 23 graphs (1)(D) and (2)(D) of section 1833(a) (42
 24 U.S.C. 1395l(a)) are each amended by striking

“subsection (h)(1),” and inserting “subsection (h)(1) or section 1834(d)(1),”.

(B) Clauses (i) and (ii) of section 1848(a)(2)(A) (42 U.S.C. 1395w-4(a)(2)(A)) are each amended by striking “a service” and inserting “a service (other than a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer or a screening colonoscopy provided to an individual at high risk for colorectal cancer for the purpose of early detection of colon cancer)”.

(C) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(i) in paragraph (1)—

(I) in subparagraph (E), by striking “and” at the end;

(II) in subparagraph (F), by striking the semicolon at the end and inserting “, and”; and

(III) by adding at the end the following new subparagraph:

“(G) in the case of screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy provided for the purpose of early detection of colon cancer, which are performed more

1 frequently than is covered under section 1834(d);”;
2 and

3 (ii) in paragraph (7), by striking “para-
4 graph (1)(B) or under paragraph (1)(F)” and
5 inserting “subparagraphs (B), (F), or (G) of
6 paragraph (1)”.

7 (d) PROSTATE CANCER SCREENING TESTS.—

8 (1) IN GENERAL.—Section 1861(s)(2) (42
9 U.S.C. 1395x(s)(2)) is amended—

10 (A) by striking “and” at the end of sub-
11 paragraph (N) and subparagraph (O); and

12 (B) by inserting after subparagraph (O)
13 the following new subparagraph:

14 “(P) prostate cancer screening tests (as defined
15 in subsection (oo)); and”.

16 (2) TESTS DESCRIBED.—Section 1861 (42
17 U.S.C. 1395x) is amended by adding at the end the
18 following new subsection:

19 “Prostate Cancer Screening Tests

20 “(oo) The term ‘prostate cancer screening test’
21 means a test that consists of a digital rectal examination
22 or a prostate-specific antigen blood test (or both) provided
23 for the purpose of early detection of prostate cancer to
24 a man over 40 years of age who has not had such a test
25 during the preceding year.”.

(3) PAYMENT FOR PROSTATE-SPECIFIC ANTI-
 GEN BLOOD TEST UNDER CLINICAL DIAGNOSTIC
 LABORATORY TEST FEE SCHEDULES.—Section
 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amend-
 ed by inserting after “laboratory tests” the follow-
 ing: “(including prostate cancer screening tests
 under section 1861(o) consisting of prostate-spe-
 cific antigen blood tests)”.

(4) CONFORMING AMENDMENT.—Section
 1862(a) (42 U.S.C. 1395y(a)), as amended by sub-
 section (c)(3)(C), is amended—

(A) in paragraph (1)—

(i) in subparagraph (F), by striking

“and” at the end,

(ii) in subparagraph (G), by striking

the semicolon at the end and inserting “,

and”, and

(iii) by adding at the end the follow-

ing new subparagraph:

“(H) in the case of prostate cancer screening
 test (as defined in section 1861(o)) provided for the
 purpose of early detection of prostate cancer, which
 are performed more frequently than is covered under
 such section;”; and

1 (B) in paragraph (7), by striking “or (G)”
2 and inserting “(G), or (H)”.

3 (e) DIABETES SCREENING BENEFITS.—

4 (1) DIABETES OUTPATIENT SELF-MANAGEMENT
5 TRAINING SERVICES.—

6 (A) IN GENERAL.—Section 1861(s)(2) (42
7 U.S.C. 1395x(s)(2)), as amended by subsection
8 (d)(1), is amended—

9 (i) by striking “and” at the end of
10 subparagraph (N);

11 (ii) by striking “and” at the end of
12 subparagraph (O); and

13 (iii) by inserting after subparagraph
14 (O) the following new subparagraph:

15 “(P) diabetes outpatient self-management train-
16 ing services (as defined in subsection (pp)); and”.

17 (B) DEFINITION.—Section 1861 (42
18 U.S.C. 1395x), as amended by subsection
19 (d)(2), is amended by adding at the end the fol-
20 lowing new subsection:

21 “DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING
22 SERVICES

23 “(pp)(1) The term ‘diabetes outpatient self-manage-
24 ment training services’ means educational and training
25 services furnished to an individual with diabetes by or
26 under arrangements with a certified provider (as described

1 in paragraph (2)(A)) in an outpatient setting by an indi-
 2 vidual or entity who meets the quality standards described
 3 in paragraph (2)(B), but only if the physician who is man-
 4 aging the individual's diabetic condition certifies that such
 5 services are needed under a comprehensive plan of care
 6 related to the individual's diabetic condition to provide the
 7 individual with necessary skills and knowledge (including
 8 skills related to the self-administration of injectable drugs)
 9 to participate in the management of the individual's condi-
 10 tion.

11 “(2) In paragraph (1)—

12 “(A) a ‘certified provider’ is an individual or
 13 entity that, in addition to providing diabetes out-
 14 patient self-management training services, provides
 15 other items or services for which payment may be
 16 made under this title; and

17 “(B) an individual or entity meets the quality
 18 standards described in this paragraph if the individ-
 19 ual or entity meets quality standards established by
 20 the Secretary, except that the individual or entity
 21 shall be deemed to have met such standards if the
 22 individual or entity meets applicable standards origi-
 23 nally established by the National Diabetes Advisory
 24 Board and subsequently revised by organizations
 25 who participated in the establishment of standards

1 by such Board, or is recognized by the American Di-
 2 abetes Association as meeting standards for furnish-
 3 ing the services.”.

4 (C) CONSULTATION WITH ORGANIZATIONS
 5 IN ESTABLISHING PAYMENT AMOUNTS FOR
 6 SERVICES PROVIDED BY PHYSICIANS.—In es-
 7 tablishing payment amounts under section
 8 1848(a) of the Social Security Act for physi-
 9 cians’ services consisting of diabetes outpatient
 10 self-management training services, the Sec-
 11 retary of Health and Human Services shall con-
 12 sult with appropriate organizations, including
 13 the American Diabetes Association, in deter-
 14 mining the relative value for such services
 15 under section 1848(c)(2) of such Act.

16 (2) BLOOD-TESTING STRIPS FOR INDIVIDUALS
 17 WITH DIABETES.—

18 (A) INCLUDING STRIPS AS DURABLE MEDI-
 19 CAL EQUIPMENT.—Section 1861(n) (42 U.S.C.
 20 1395x(n)) is amended by striking the semicolon
 21 in the first sentence and inserting the following:
 22 “, and includes blood-testing strips for individ-
 23 uals with diabetes without regard to whether
 24 the individual has Type I or Type II diabetes
 25 (as determined under standards established by

1 the Secretary in consultation with the American
2 Diabetes Association);”.

3 (2) PAYMENT FOR STRIPS BASED ON METH-
4 ODOLOGY FOR INEXPENSIVE AND ROUTINELY PUR-
5 CHASED EQUIPMENT.—Section 1834(a)(2)(A) (42
6 U.S.C. 1395m(a)(2)(A)) is amended—

7 (A) by striking “or” at the end of clause
8 (ii);

9 (B) by adding “or” at the end of clause
10 (iii); and

11 (C) by inserting after clause (iii) the fol-
12 lowing new clause:

13 “(iv) which is a blood-testing strip for
14 an individual with diabetes,”.

15 (e) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to items and services furnished on
17 or after January 1, 1996.

18 **Subtitle E—Medicare Fraud** 19 **Reduction**

20 **SEC. 15401. INCREASING BENEFICIARY AWARENESS OF** 21 **FRAUD AND ABUSE.**

22 (a) BENEFICIARY OUTREACH EFFORTS.—The Sec-
23 retary of Health and Human Services (acting through the
24 Administrator of the Health Care Financing Administra-
25 tion and the Inspector General of the Department of

1 Health and Human Services) shall make ongoing efforts
 2 (through public service announcements, publications, and
 3 other appropriate methods) to alert individuals entitled to
 4 benefits under the medicare program of the existence of
 5 fraud and abuse committed against the program and the
 6 costs to the program of such fraud and abuse, and of the
 7 existence of the toll-free telephone line operated by the
 8 Secretary to receive information on fraud and abuse com-
 9 mitted against the program.

10 (b) CLARIFICATION OF REQUIREMENT TO PROVIDE
 11 EXPLANATION OF MEDICARE BENEFITS.—The Secretary
 12 shall provide an explanation of benefits under the medi-
 13 care program with respect to each item or service for
 14 which payment may be made under the program which
 15 is furnished to an individual, without regard to whether
 16 or not a deductible or coinsurance may be imposed against
 17 the individual with respect to the item or service.

18 (c) PROVIDER OUTREACH EFFORTS; PUBLICATION
 19 OF FRAUD ALERTS.—

20 (1) SPECIAL FRAUD ALERTS.—

21 (A) IN GENERAL.—

22 (i) REQUEST FOR SPECIAL FRAUD
 23 ALERTS.—Any person may present, at any
 24 time, a request to the Secretary to issue
 25 and publish a special fraud alert.

(ii) SPECIAL FRAUD ALERT DEFINED.—In this section, a “special fraud alert” is a notice which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act).

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—

(i) INVESTIGATION.—Upon receipt of a request for a special fraud alert under subparagraph (A), the Secretary shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Secretary (in consultation with the Attorney General) shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(ii) CRITERIA FOR ISSUANCE.—In determining whether to issue a special fraud

1 alert upon a request under subparagraph
2 (A), the Secretary may consider—

3 (I) whether and to what extent
4 the practices that would be identified
5 in the special fraud alert may result
6 in any of the consequences described
7 in subparagraph (C); and

8 (II) the extent and frequency of
9 the conduct that would be identified
10 in the special fraud alert.

11 (C) CONSEQUENCES DESCRIBED.—The
12 consequences described in this subparagraph
13 are as follows:

14 (i) An increase or decrease in access
15 to health care services.

16 (ii) An increase or decrease in the
17 quality of health care services.

18 (iii) An increase or decrease in patient
19 freedom of choice among health care pro-
20 viders.

21 (iv) An increase or decrease in com-
22 petition among health care providers.

23 (v) An increase or decrease in the cost
24 to health care programs of the Federal
25 Government.

(vi) An increase or decrease in the potential overutilization of health care services.

(vii) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in health care programs of the Federal Government.

(2) PUBLICATION OF ALL HCFA FRAUD ALERTS IN FEDERAL REGISTER.—Each notice issued by the Health Care Financing Administration which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act) shall be published in the Federal Register, without regard to whether or not the notice is issued by a regional office of the Health Care Financing Administration.

SEC. 15402. BENEFICIARY INCENTIVES TO REPORT FRAUD AND ABUSE.

(a) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program

1 under which the Secretary shall encourage individ-
 2 uals to report to the Secretary information on indi-
 3 viduals and entities who are engaging or who have
 4 engaged in acts or omissions which constitute
 5 grounds for the imposition of a sanction under sec-
 6 tion 1128, section 1128A, or section 1128B of the
 7 Social Security Act, or who have otherwise engaged
 8 in fraud and abuse against the medicare program.

9 (2) PAYMENT OF PORTION OF AMOUNTS COL-
 10 LECTED.—If an individual reports information to
 11 the Secretary under the program established under
 12 paragraph (1) which serves as the basis for the col-
 13 lection by the Secretary or the Attorney General of
 14 any amount of at least \$100 (other than any
 15 amount paid as a penalty under section 1128B of
 16 the Social Security Act), the Secretary may pay a
 17 portion of the amount collected to the individual
 18 (under procedures similar to those applicable under
 19 section 7623 of the Internal Revenue Code of 1986
 20 to payments to individuals providing information on
 21 violations of such Code).

22 (b) PROGRAM TO COLLECT INFORMATION ON PRO-
 23 GRAM EFFICIENCY.—

24 (1) ESTABLISHMENT OF PROGRAM.—Not later
 25 than 3 months after the date of the enactment of

this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 15403. ELIMINATION OF HOME HEALTH OVERPAYMENTS.

(a) REQUIRING BILLING AND PAYMENT TO BE BASED ON SITE WHERE SERVICE FURNISHED.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following new subsection:

“(g) A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished during cost reporting periods beginning on or after October 1, 1995.

1 **SEC. 15404. SKILLED NURSING FACILITIES.**

2 (a) CLARIFICATION OF TREATMENT OF HOSPITAL
3 TRANSFERS.—Section 1886(d)(5)(I) (42 U.S.C.
4 1395ww(d)(5)(I)) is amended by adding at the end the
5 following new clause:

6 “(iii) In making adjustments under clause (i) for
7 transfer cases, the Secretary shall treat as a transfer any
8 transfer to a hospital (without regard to whether or not
9 the hospital is a subsection (d) hospital), a unit thereof,
10 or a skilled nursing facility.”.

11 (b) EFFECTIVE DATE.—The amendment made by
12 subsection (a) shall apply to discharges occurring on or
13 after October 1, 1995.

14 **SEC. 15405. DIRECT SPENDING FOR ANTI-FRAUD ACTIVI-**
15 **TIES UNDER MEDICARE.**

16 (a) ESTABLISHMENT OF MEDICARE INTEGRITY PRO-
17 GRAM.—Title XVIII, as amended by section 15231(d) and
18 section 15302(b), is further amended by adding at the end
19 the following new section:

20 “MEDICARE INTEGRITY PROGRAM

21 “SEC. 1895. (a) ESTABLISHMENT OF PROGRAM.—
22 There is hereby established the Medicare Integrity Pro-
23 gram (hereafter in this section referred to as the ‘Pro-
24 gram’) under which the Secretary shall promote the integ-
25 rity of the medicare program by entering into contracts

1 in accordance with this section with eligible private entities
2 to carry out the activities described in subsection (b).

3 “(b) ACTIVITIES DESCRIBED.—The activities de-
4 scribed in this subsection are as follows:

5 “(1) Review of activities of providers of services
6 or other individuals and entities furnishing items
7 and services for which payment may be made under
8 this title (including skilled nursing facilities and
9 home health agencies), including medical and utiliza-
10 tion review and fraud review (employing similar
11 standards, processes, and technologies used by pri-
12 vate health plans, including equipment and software
13 technologies which surpass the capability of the
14 equipment and technologies used in the review of
15 claims under this title as of the date of the enact-
16 ment of this section).

17 “(2) Audit of cost reports.

18 “(3) Determinations as to whether payment
19 should not be, or should not have been, made under
20 this title by reason of section 1862(b), and recovery
21 of payments that should not have been made.

22 “(4) Education of providers of services, bene-
23 ficiaries, and other persons with respect to payment
24 integrity and benefit quality assurance issues.

1 “(c) ELIGIBILITY OF ENTITIES.—An entity is eligible
2 to enter into a contract under the Program to carry out
3 any of the activities described in subsection (b) if—

4 “(1) the entity has demonstrated capability to
5 carry out such activities;

6 “(2) in carrying out such activities, the entity
7 agrees to cooperate with the Inspector General of
8 the Department of Health and Human Services, the
9 Attorney General of the United States, and other
10 law enforcement agencies, as appropriate, in the in-
11 vestigation and deterrence of fraud and abuse in re-
12 lation to this title and in other cases arising out of
13 such activities;

14 “(3) the entity’s financial holdings, interests, or
15 relationships will not interfere with its ability to per-
16 form the functions to be required by the contract in
17 an effective and impartial manner; and

18 “(4) the entity meets such other requirements
19 as the Secretary may impose.

20 “(d) PROCESS FOR ENTERING INTO CONTRACTS.—
21 The Secretary shall enter into contracts under the Pro-
22 gram in accordance with such procedures as the Secretary
23 may by regulation establish, except that such procedures
24 shall include the following:

“(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

“(2) The provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section, except that competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary.

“(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

“(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor’s liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

“(f) TRANSFER OF AMOUNTS TO MEDICARE ANTI-FRAUD AND ABUSE TRUST FUND.—For each fiscal year,

1 the Secretary shall transfer from the Federal Hospital In-
 2 surance Trust Fund and the Federal Supplementary Med-
 3 ical Insurance Trust Fund to the Medicare Anti-Fraud
 4 and Abuse Trust Fund under subsection (g) such amounts
 5 as are necessary to carry out the activities described in
 6 subsection (b). Such transfer shall be in an allocation as
 7 reasonably reflects the proportion of such expenditures as-
 8 sociated with part A and part B.

9 “(g) MEDICARE ANTI-FRAUD AND ABUSE TRUST
 10 FUND.—

11 “(1) ESTABLISHMENT.—

12 “(A) IN GENERAL.—There is hereby estab-
 13 lished in the Treasury of the United States the
 14 Anti-Fraud and Abuse Trust Fund (hereafter
 15 in this subsection referred to as the ‘Trust
 16 Fund’). The Trust Fund shall consist of such
 17 gifts and bequests as may be made as provided
 18 in subparagraph (B) and such amounts as may
 19 be deposited in the Trust Fund as provided in
 20 subsection (f).

21 “(B) AUTHORIZATION TO ACCEPT GIFTS
 22 AND BEQUESTS.—The Trust Fund is author-
 23 ized to accept on behalf of the United States
 24 money gifts and bequests made unconditionally
 25 to the Trust Fund, for the benefit of the Trust

Fund or any activity financed through the Trust Fund.

“(2) INVESTMENT.—

“(A) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund in government account serial securities.

“(B) USE OF INCOME.—Any interest derived from investments under subparagraph (A) shall be credited to the Fund.

“(3) DIRECT APPROPRIATION OF FUNDS TO CARRY OUT PROGRAM.—

“(A) IN GENERAL.—There are appropriated from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under this section, subject to subparagraph (B).

“(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

“(i) For fiscal year 1996, such amount shall be not less than \$430,000,000 and not more than \$440,000,000.

1 “(ii) For fiscal year 1997, such
2 amount shall be not less than
3 \$490,000,000 and not more than
4 \$500,000,000.

5 “(iii) For fiscal year 1998, such
6 amount shall be not less than
7 \$550,000,000 and not more than
8 \$560,000,000.

9 “(iv) For fiscal year 1999, such
10 amount shall be not less than
11 \$620,000,000 and not more than
12 \$630,000,000.

13 “(v) For fiscal year 2000, such
14 amount shall be not less than
15 \$670,000,000 and not more than
16 \$680,000,000.

17 “(vi) For fiscal year 2001, such
18 amount shall be not less than
19 \$690,000,000 and not more than
20 \$700,000,000.

21 “(vii) For fiscal year 2002, such
22 amount shall be not less than
23 \$710,000,000 and not more than
24 \$720,000,000.

1 “(4) ANNUAL REPORT.—The Secretary shall
2 submit an annual report to Congress on the amount
3 of revenue which is generated and disbursed by the
4 Trust Fund in each fiscal year.”.

5 (b) ELIMINATION OF FI AND CARRIER RESPONSIBIL-
6 ITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PRO-
7 GRAM.—

8 (1) RESPONSIBILITIES OF FISCAL
9 INTERMEDIARIES UNDER PART A.—Section 1816
10 (42 U.S.C. 1395h) is amended by adding at the end
11 the following new subsection:

12 “(l) No agency or organization may carry out (or re-
13 ceive payment for carrying out) any activity pursuant to
14 an agreement under this section to the extent that the ac-
15 tivity is carried out pursuant to a contract under the Med-
16 icare Integrity Program under section 1895.”.

17 (2) RESPONSIBILITIES OF CARRIERS UNDER
18 PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is
19 amended by adding at the end the following new
20 paragraph:

21 “(6) No carrier may carry out (or receive payment
22 for carrying out) any activity pursuant to a contract under
23 this subsection to the extent that the activity is carried
24 out pursuant to a contract under the Medicare Integrity
25 Program under section 1895.”.

1 (c) DIRECT SPENDING FOR MEDICARE-RELATED AC-
2 TIVITIES OF INSPECTOR GENERAL.—Section 1895, as
3 added by subsection (a), is amended by adding at the end
4 the following new subsection:

5 “(h) DIRECT SPENDING FOR MEDICARE-RELATED
6 ACTIVITIES OF INSPECTOR GENERAL.—

7 “(1) IN GENERAL.—There are appropriated
8 from the Federal Hospital Insurance Trust Fund
9 and the Federal Supplementary Medical Insurance
10 Trust Fund to the Inspector General of the Depart-
11 ment of Health and Human Services for each fiscal
12 year such amounts as are necessary to enable the
13 Inspector General to carry out activities relating to
14 the medicare program (as described in paragraph
15 (2)), subject to paragraph (3).

16 “(2) ACTIVITIES DESCRIBED.—The activities
17 described in this paragraph are as follows:

18 “(A) Prosecuting medicare-related matters
19 through criminal, civil, and administrative pro-
20 ceedings.

21 “(B) Conducting investigations relating to
22 the medicare program.

23 “(C) Performing financial and performance
24 audits of programs and operations relating to
25 the medicare program.

“(D) Performing inspections and other evaluations relating to the medicare program.

“(E) Conducting provider and consumer education activities regarding the requirements of this title.

“(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

“(A) For fiscal year 1996, such amount shall be \$130,000,000.

“(B) For fiscal year 1997, such amount shall be \$181,000,000.

“(C) For fiscal year 1998, such amount shall be \$204,000,000.

“(D) For each subsequent fiscal year, the amount appropriated for the previous fiscal year, increased by the percentage increase in aggregate expenditures under this title for the fiscal year involved over the previous fiscal year.

“(4) ALLOCATION OF PAYMENTS AMONG TRUST FUNDS.—The appropriations made under paragraph (1) shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.”.

1 **SEC. 15406. FRAUD REDUCTION DEMONSTRATION**
 2 **PROJECT.**

3 (a) IN GENERAL.—Not later than July 1, 1996, the
 4 Secretary of Health and Human Services (in this section
 5 referred to as the “Secretary”) shall establish not less
 6 than three demonstration projects under which organiza-
 7 tions with a contract under section 1816 or section 1842
 8 of the Social Security Act—

- 9 (1) identify practitioners and providers whose
 10 patterns of providing care to beneficiaries enrolled
 11 under title XVIII of the Social Security Act are con-
 12 sistently outside the norm for other practitioners or
 13 providers of the same category, class, or type, and
 14 (2) experiment with ways of identifying fraudu-
 15 lent claims submitted to the program established
 16 under such title before they are paid.

17 (b) DURATION OF PROJECTS.—Each project estab-
 18 lished under subsection (a) shall last for at least 18
 19 months and shall focus on those categories, classes, or
 20 types of providers and practitioners that have been identi-
 21 fied by the Inspector General of the Department of Health
 22 and Human Services as having a high incidence of fraud
 23 and abuse.

24 (c) REPORT.—Not later than July 1, 1997, the Sec-
 25 retary shall report to the Congress on the demonstration
 26 projects established under subsection (a), and shall include

1 in the report an assessment of the effectiveness of, and
2 any recommended legislative changes based on, the
3 projects.

4 **SEC. 15407. REPORT ON COMPETITIVE PRICING.**

5 Not later than 1 year after the date of the enactment
6 of this Act, the Secretary of Health and Human Services
7 (acting through the Administrator of the Health Care Fi-
8 nancing Administration) shall submit to Congress a report
9 recommending legislative changes to the medicare pro-
10 gram to enable the prices paid for items and services
11 under the medicare program to be established on a more
12 competitive basis.

13 **Subtitle F—Improving Access to**
14 **Health Care**

15 **PART 1—IMPROVING ACCESS TO HEALTH CARE**
16 **IN RURAL AREAS**

17 **SEC. 15501. COMMUNITY RURAL HEALTH NETWORK**
18 **GRANTS.**

19 (a) ASSISTANCE FOR DEVELOPMENT OF ACCESS
20 PLANS FOR CHRONICALLY UNDERSERVED AREAS.—

21 (1) AVAILABILITY OF FINANCIAL ASSISTANCE
22 TO IMPLEMENT ACTION PLANS TO INCREASE AC-
23 CESS.—

24 (A) IN GENERAL.—The Secretary shall
25 provide grants (in amounts determined in ac-

1 cordance with subparagraph (C)) over a 3-year
 2 period to an eligible State for the development
 3 of plans to increase access to health care serv-
 4 ices during such period for residents of areas in
 5 the State that are designated as chronically un-
 6 derserved areas in accordance with paragraph
 7 (2).

8 (B) ELIGIBILITY REQUIREMENTS.—A
 9 State is eligible to receive grants under this sec-
 10 tion if the State submits to the Secretary (at
 11 such time and in such form as the Secretary
 12 may require) assurances that the State has de-
 13 veloped (or is in the process of developing) a
 14 plan to increase the access of residents of a
 15 chronically underserved area to health care
 16 services that meets the requirements of para-
 17 graph (3), together with such other information
 18 and assurances as the Secretary may require.

19 (C) AMOUNT OF ASSISTANCE.—

20 (i) IN GENERAL.—Subject to clause
 21 (ii), the amount of assistance provided to
 22 a State under this subsection with respect
 23 to any plan during a 3-year period shall be
 24 equal to—

(I) for the first year of the period, an amount equal to 100 percent of the amounts expended by the State during the year to implement the plan described in subparagraph (A) (as reported to the Secretary in accordance with such requirements as the Secretary may impose);

(II) for the second year of the period, an amount equal to 50 percent of the amounts expended by the State during the year to implement the plan; and

(III) for the third year of the period, an amount equal to 33 percent of the amounts expended by the State during the year to implement the plan.

(ii) AGGREGATE PER PLAN LIMIT.—

The amount of assistance provided to a State under this paragraph with respect to any plan may not exceed \$100,000 during any year of the 3-year period for which the State receives assistance.

(2) DESIGNATION OF AREAS.—

1 (A) DESIGNATION BY GOVERNOR.—In ac-
 2 cordance with the guidelines developed under
 3 subparagraph (B), the Governor of a State may
 4 designate an area in the State as a chronically
 5 underserved area for purposes of this section
 6 upon the request of a local official of the area
 7 or upon the Governor's initiative.

8 (B) GUIDELINES FOR DESIGNATION.—

9 (i) DEVELOPMENT BY SECRETARY.—

10 Not later than 1 year after the date of the
 11 enactment of this Act, the Secretary shall
 12 develop guidelines for the designation of
 13 areas as chronically underserved areas
 14 under this subsection.

15 (ii) FACTORS CONSIDERED IN DEVEL-
 16 OPMENT OF GUIDELINES.—In developing
 17 guidelines under subparagraph (A), the
 18 Secretary shall consider the following fac-
 19 tors:

20 (I) Whether the area (or a sig-
 21 nificant portion of the area)—

22 (aa) is designated as a
 23 health professional shortage area
 24 (under section 332(a) of the Pub-
 25 lic Health Service Act), or meets

1 the criteria for designation as
2 such an area; or

3 (bb) was previously des-
4 igned as such an area or pre-
5 viously met such criteria for an
6 extended period prior to the des-
7 ignation of the area under this
8 subsection (in accordance with
9 criteria established by the Sec-
10 retary).

11 (II) The availability and ade-
12 quacy of health care providers and fa-
13 cilities for residents of the area.

14 (III) The extent to which the
15 availability of assistance under other
16 Federal and State programs has failed
17 to alleviate the lack of access to
18 health care services for residents of
19 the area.

20 (IV) The percentage of residents
21 of the area whose income is at or
22 below the poverty level.

23 (V) The percentage of residents
24 of the area who are age 65 or older.

1 (VI) The existence of cultural or
2 geographic barriers to access to health
3 care services in the area, including
4 weather conditions.

5 (C) REVIEW BY SECRETARY.—No designa-
6 tion under subparagraph (A) shall take effect
7 under this subsection unless the Secretary—

8 (i) has been notified of the proposed
9 designation; and

10 (ii) has not, within 60 days after the
11 date of receipt of the notice, disapproved
12 the designation.

13 (D) PERIOD OF DESIGNATION.—A designa-
14 tion under this subsection shall be effective dur-
15 ing a period specified by the Governor of not
16 longer than 3 years. The Governor may extend
17 the designation for additional 3-year periods,
18 except that a State may not receive assistance
19 under paragraph (1)(C) for amounts expended
20 during any such additional periods.

21 (3) REQUIREMENTS FOR STATE ACCESS
22 PLANS.—A State plan to increase the access of resi-
23 dents of chronically underserved areas to health care
24 services meets the requirements of this subsection if
25 the Secretary finds that the plan was developed with

the participation of health care providers and facilities and residents of the area that is the subject of the plan, together with such other requirements as the Secretary may impose.

(4) AUTHORIZATION OF APPROPRIATIONS.—

There are authorized to be appropriated for assistance under this subsection \$10,000,000 for each of the first 3 fiscal years beginning after the date on which the Secretary develops guidelines for the designation of areas as chronically underserved areas under paragraph (2)(B).

(b) TECHNICAL ASSISTANCE GRANTS FOR NETWORKS.—

(1) IN GENERAL.—The Secretary shall make funds available under this subsection to provide technical assistance (including information regarding eligibility for other Federal programs) and advice for entities described in paragraph (2) seeking to establish or enhance a community rural health network in an underserved rural area.

(2) ENTITIES ELIGIBLE TO RECEIVE FUNDS.—

The following entities are eligible to receive funds for technical assistance under this subsection:

(A) An entity receiving a grant under subsection (c).

1 (B) A State or unit of local government.

2 (C) An entity providing health care serv-
3 ices (including health professional education
4 services) in the area involved.

5 (3) USE OF FUNDS.—

6 (A) IN GENERAL.—Funds made available
7 under this subsection may be used—

8 (i) for planning a community rural
9 health network and the submission of the
10 plan for the network to the Secretary
11 under subsection (c)(3) (subject to the lim-
12 itation described in subparagraph (B));

13 (ii) to provide assistance in conduct-
14 ing community-based needs and
15 prioritization, identifying existing regional
16 health resources, and developing networks,
17 utilizing existing local providers and facili-
18 ties where appropriate;

19 (iii) to provide advice on obtaining the
20 proper balance of primary and secondary
21 facilities for the population served by the
22 network;

23 (iv) to provide assistance in coordinat-
24 ing arrangements for tertiary care;

(v) to provide assistance in recruitment and retention of health care professionals;

(vi) to provide assistance in coordinating the delivery of emergency services with the provision of other health care services in the area served by the network;

(vii) to provide assistance in coordinating arrangements for mental health and substance abuse treatment services; and

(viii) to provide information regarding the area or proposed network's eligibility for Federal and State assistance for health care-related activities, together with information on funds available through private sources.

(B) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in subparagraph (A) may not exceed \$50,000 and may not be available for a period of time exceeding 1 year.

(4) USE OF RURAL HEALTH OFFICES.—In carrying out this subsection with respect to entities in rural areas, the Secretary shall make funds available

1 through the State offices of rural health or through
2 appropriate entities designated by such offices.

3 (5) AUTHORIZATION OF APPROPRIATIONS.—

4 There are authorized to be appropriated
5 \$10,000,000 for each of fiscal years 1996 through
6 2000 to carry out this section. Amounts appro-
7 priated under this subsection shall be available until
8 expended.

9 (c) DEVELOPMENT GRANTS FOR NETWORKS.—

10 (1) IN GENERAL.—The Secretary shall provide
11 financial assistance to eligible entities for the pur-
12 pose of providing for the development and implemen-
13 tation of community rural health networks (as de-
14 fined in subsection (d)). In providing such assist-
15 ance, the Secretary shall give priority to eligible enti-
16 ties that will carry out such purpose in States that
17 have developed a plan under subsection (a).

18 (2) ELIGIBLE ENTITIES.—

19 (A) IN GENERAL.—An entity is eligible to
20 receive financial assistance under this sub-
21 section only if the entity meets the require-
22 ments of clauses (i) through (iii) as follows:

23 (i) The entity—

24 (I) is based in a rural area;

(II) is described in subparagraph (B), (C), or (D) of subsection (b)(2);or

(III) is a hospital-affiliated primary care center (as defined in subsection (d)).

(ii) The entity is undertaking to develop and implement a community rural health network in one or more underserved rural areas (as defined in subsection (d)) with the active participation of at least 3 health care providers or facilities in the area.

(iii) The entity has consulted with the local governments of the area to be served by the network and with individuals who reside in the area.

(B) COORDINATION WITH PROVIDERS OUTSIDE OF AREA PERMITTED.—Nothing in this subsection shall be construed as preventing an entity that coordinates the delivery of services in an underserved rural area with an entity outside the area from qualifying for financial assistance under this section, or as preventing an entity consisting of a consortia of members lo-

1 cated in adjoining States from qualifying for
2 such assistance.

3 (C) PERMITTING ENTITIES NOT RECEIVING
4 FUNDING FOR DEVELOPMENT OF PLAN TO RE-
5 CEIVE FUNDING FOR IMPLEMENTATION.—An
6 entity that is eligible to receive financial assist-
7 ance under this subsection may receive assist-
8 ance to carry out activities described in para-
9 graph (3)(A)(ii) notwithstanding that the entity
10 does not receive assistance to carry out activi-
11 ties described in paragraph (c)(A)(i).

12 (3) USE OF FUNDS.—

13 (A) IN GENERAL.—Financial assistance
14 made available to eligible entities under this
15 subsection may be used only—

16 (ii) for the development of a commu-
17 nity health network and the submission of
18 the plan for the network to the Secretary;
19 and

20 (ii) after the Secretary approves the
21 plan for the network, for activities to im-
22 plement the network, including (but not
23 limited to)—

24 (I) establishing information sys-
25 tems, including telecommunications,

(II) recruiting health care providers,

(III) providing services to enable individuals to have access to health care services, including transportation and language interpretation services (including interpretation services for the hearing-impaired), and

(IV) establishing and operating a community health advisor program described in subparagraph (B).

(B) COMMUNITY HEALTH ADVISOR PROGRAM.—

(i) PROGRAM DESCRIBED.—In subparagraph (A), a “community health advisor program” is a program under which community health advisors carry out the following activities:

(I) Collaborating efforts with health care providers and related entities to facilitate the provision of health services and health-related social services.

(II) Providing public education on health promotion and disease pre-

1 vention and efforts to facilitate the
2 use of available health services and
3 health-related social services.

4 (III) Providing health-related
5 counseling.

6 (IV) Making referrals for avail-
7 able health services and health-related
8 social services.

9 (V) Improving the ability of indi-
10 viduals to use health services and
11 health-related social services under
12 Federal, State, and local programs
13 through assisting individuals in estab-
14 lishing eligibility under the programs.

15 (VI) Providing outreach services
16 to inform the community of the avail-
17 ability of the services provided under
18 the program.

19 (ii) COMMUNITY HEALTH ADVISOR
20 DEFINED.—In clause (i), the term “com-
21 munity health advisor” means, with re-
22 spect to a community health advisor pro-
23 gram, an individual—

24 (I) who has demonstrated the ca-
25 pacity to carry out one or more of the

activities carried out under the program; and

(II) who, for not less than one year, has been a resident of the community in which the program is to be operated.

(C) LIMITATIONS ON ACTIVITIES FUNDED.—Financial assistance made available under this subsection may not be used for any of the following:

(i) For a telecommunications system unless such system is coordinated with, and does not duplicate, a system existing in the area.

✓ (ii) For construction or remodeling of health care facilities.

(D) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in subparagraph (A)(i) may not exceed \$50,000 and may not be made available for a period of time exceeding 1 year.

(4) APPLICATION.—

(A) IN GENERAL.—No financial assistance shall be provided under this section to an entity

1 unless the entity has submitted to the Sec-
2 retary, in a time and manner specified by the
3 Secretary, and had approved by the Secretary
4 an application.

5 (B) INFORMATION TO BE INCLUDED.—

6 Each such application shall include—

7 (i) a description of the community
8 rural health network, including service
9 area and capacity, and

10 (ii) a description of how the proposed
11 network will utilize existing health care fa-
12 cilities in a manner that avoids unneces-
13 sary duplication.

14 (5) AUTHORIZATION OF APPROPRIATIONS.—

15 (A) IN GENERAL.—There are authorized to
16 be appropriated \$100,000,000 for each of fiscal
17 years 1996 through 2000 to carry out this sub-
18 section. Amounts appropriated under this sub-
19 section shall be available until expended.

20 (B) ANNUAL LIMIT ON ASSISTANCE TO
21 GRANTEE.—The amount of financial assistance
22 provided to an entity under this subsection dur-
23 ing a year may not exceed \$250,000.

24 (d) DEFINITIONS.—

25 (1) IN GENERAL.—

(A) COMMUNITY RURAL HEALTH NETWORK.—For purposes of this section, the term “community rural health network” means a formal cooperative arrangement between participating hospitals, physicians, and other health care providers which—

(i) is located in an underserved rural area;

(ii) furnishes health care services to individuals residing in the area; and

(iii) is governed by a board of directors selected by participating health care providers and residents of the area.

(B) HOSPITAL-AFFILIATED PRIMARY CARE CENTER.—

(i) IN GENERAL.—For purposes of this section, the term “hospital-affiliated primary care center” means a distinct administrative unit of a community hospital (as defined in clause (ii)) meeting the following requirement:

(I) The unit is located in, or adjacent to, the hospital.

(II) The unit delivers primary health services, as defined in para-

1 graph (1) of section 330(b) of the
2 Public Health Service Act to a
3 catchment area determined by the
4 hospital and approved by the Sec-
5 retary.

6 (III) The unit provides referrals
7 to providers of supplemental health
8 services, as defined in paragraph (2)
9 of such section.

10 (IV) The services of the unit are
11 delivered through a primary care
12 group practice (as defined in clause
13 (iii)).

14 (V) To the extent practicable,
15 primary health services in the commu-
16 nity hospital are delivered only
17 through the unit.

18 (VI) Qualified personnel trained
19 in triage are placed in the unit, the
20 emergency room, and the outpatient
21 department to screen and direct pa-
22 tients to the appropriate location for
23 care.

24 (VII) Each patient of the unit
25 has an identified member of the group

1 practice responsible for continuous
2 management of the patient, including
3 emergency services and referrals of
4 the patients for inpatient or out-
5 patient services.

6 (VIII) To the extent practicable,
7 excess facilities and equipment in or
8 owned by the community hospital are
9 covered for use in the unit.

10 (IX) The unit and the hospital
11 avoid unnecessary duplication of fa-
12 cilities and equipment, except that the
13 unit may install appropriate support
14 equipment for routine primary health
15 services.

16 (X) The unit is maintained as a
17 separate and distinct cost and revenue
18 center for accounting purposes.

19 (XI) The unit is operated in ac-
20 cordance with all of the requirements
21 specified for community health centers
22 in section 330(e)(3) of the Public
23 Health Service Act (other than clause
24 (vii)).

1 (XII) The hospital has an advi-
2 sory committee that—

3 (aa) is composed of individ-
4 uals a majority of whom are
5 health consumers in the
6 catchment area of the hospital;
7 and

8 (bb) meets at least 6 times a
9 year to review the operations of
10 the primary care center and de-
11 velop recommendations to the
12 governing board of the hospital
13 about the operation of the center
14 and the types of services to be
15 provided.

16 (XIII) The unit maintains an in-
17 formation program for its patients
18 that fully discloses—

19 (aa) the covered professional
20 services and referral capabilities
21 offered by the unit; and

22 (bb) the method by which
23 patients of the unit may resolve
24 grievances about billing for cov-

1 ered professional services and the
2 quality of such services.

3 (ii) COMMUNITY HOSPITAL.—For pur-
4 poses of this section, the term “community
5 hospital” means a public general hospital,
6 owned and operated by a State, county or
7 local unit of government, or a private com-
8 munity hospital that—

9 (i) has less than 50 beds; and

10 (ii) primarily serves—

11 (I) a medically underserved popu-
12 lation, as defined in section 330(b)(3)
13 of the Public Health Service Act; or

14 (II) a health professional short-
15 age area, as defined in section
16 332(a)(1) of such Act.

17 (iii) PRIMARY CARE GROUP PRAC-
18 TICE.—For purposes of this section, the
19 term “primary care group practice” means
20 any combination of 3 or more primary care
21 physicians who are—

22 (I) organized to provide primary
23 health services in a manner that is
24 consistent with the needs of the popu-
25 lation served;

1 (II) located in, or adjacent to,
2 the community hospital;

3 (III) who have admitting privi-
4 leges at the community hospital; and

5 (IV)(aa) who are salaried by the
6 hospital such that a majority of the
7 members of the group practice is full
8 time in the primary care center; or

9 (bb) who are organized into a
10 legal entity (partnership, corporation,
11 or professional association) that has a
12 contract approved by the Secretary
13 with the community hospital to pro-
14 vide primary health services.

15 (2) OTHER DEFINITIONS.—For purposes of this
16 section:

17 (A) The term “rural area” has the mean-
18 ing given such term in section 1886(d)(2)(D) of
19 the Social Security Act.

20 (B) The term “Secretary” means the Sec-
21 retary of Health and Human Services.

22 (C) The term “State” means each of the
23 several States, the District of Columbia, Puerto
24 Rico, the Virgin Islands, Guam, the Northern
25 Mariana Islands, and American Samoa.

(D) The term “underserved rural area” means a rural area designated—

(i) as a health professional shortage area under section 332(a) of the Public Health Service Act; or

(ii) as a chronically underserved area under subsection (a).

SEC. 15502. PROVIDER INCENTIVES.

(a) ADDITIONAL PAYMENTS UNDER MEDICARE FOR PHYSICIANS’ SERVICES FURNISHED IN SHORTAGE AREAS.—

(1) INCREASE IN AMOUNT OF ADDITIONAL PAYMENT.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking “10 percent” and inserting “20 percent”.

(2) RESTRICTION TO PRIMARY CARE SERVICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by inserting after “physicians’ services” the following: “consisting of primary care services (as defined in section 1842(i)(4))”.

(3) EXTENSION OF PAYMENT FOR FORMER SHORTAGE AREAS.—

(A) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking “area,” and inserting “area (or, in the case of

1 an area for which the designation as a health
2 professional shortage area under such section is
3 withdrawn, in the case of physicians' services
4 furnished to such an individual during the 3-
5 year period beginning on the effective date of
6 the withdrawal of such designation),”.

7 (B) EFFECTIVE DATE.—The amendment
8 made by subparagraph (A) shall apply to physi-
9 cians' services furnished in an area for which
10 the designation as a health professional short-
11 age area under section 332(a)(1)(A) of the
12 Public Health Service Act is withdrawn on or
13 after January 1, 1996.

14 (4) REQUIRING CARRIERS TO REPORT ON SERV-
15 ICES PROVIDED.—Section 1842(b)(3) (42 U.S.C.
16 1395u(b)(3)) is amended—

17 (A) by striking “and” at the end of sub-
18 paragraph (I); and

19 (B) by inserting after subparagraph (I) the
20 following new subparagraph:

21 “(J) will provide information to the Secretary
22 not later than 30 days after the end of the contract
23 year on the types of providers to whom the carrier
24 made additional payments during the year for cer-
25 tain physicians' services pursuant to section

1833(m), together with a description of the services furnished by such providers during the year; and”.

(5) STUDY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study analyzing the effectiveness of the provision of additional payments under part B of the medicare program for physicians’ services provided in health professional shortage areas in recruiting and retaining physicians to provide services in such areas.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subparagraph (A), and shall include in the report such recommendations as the Secretary considers appropriate.

(6) EFFECTIVE DATE.—The amendments made by paragraphs (1), (2), and (4) shall apply to physicians’ services furnished on or after January 1, 1996.

(b) DEVELOPMENT OF MODEL STATE SCOPE OF PRACTICE LAW.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop and publish a model

1 law that may be adopted by States to increase the
2 access of individuals residing in underserved rural
3 areas to health care services by expanding the serv-
4 ices which non-physician health care professionals
5 may provide in such areas.

6 (2) DEADLINE.—The Secretary shall publish
7 the model law developed under paragraph (1) not
8 later than 1 year after the date of the enactment of
9 this Act.

10 **SEC. 8503. MODIFICATIONS TO THE NATIONAL HEALTH**
11 **SERVICE CORPS.**

12 (a) NATIONAL HEALTH SERVICE CORPS LOAN RE-
13 PAYMENTS EXCLUDED FROM GROSS INCOME.—

14 (1) IN GENERAL.—Part III of subchapter B of
15 chapter 1 of the Internal Revenue Code of 1986 (re-
16 lating to items specifically excluded from gross in-
17 come) is amended by redesignating section 137 as
18 section 138 and by inserting after section 136 the
19 following new section:

20 **“SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN RE-**
21 **PAYMENTS.**

22 “(a) GENERAL RULE.—Gross income shall not in-
23 clude any qualified loan repayment.

24 “(b) QUALIFIED LOAN REPAYMENT.—For purposes
25 of this section, the term ‘qualified loan repayment’ means

1 any payment made on behalf of the taxpayer by the Na-
2 tional Health Service Corps Loan Repayment Program
3 under section 338B(g) of the Public Health Service Act.”.

4 (2) CONFORMING AMENDMENT.—Paragraph (3)
5 of section 338B(g) of the Public Health Service Act
6 is amended by striking “Federal, State, or local”
7 and inserting “State or local”.

8 (3) CLERICAL AMENDMENT.—The table of sec-
9 tions for part III of subchapter B of chapter 1 of
10 the Internal Revenue Code of 1986 is amended by
11 striking the item relating to section 137 and insert-
12 ing the following:

“Sec. 137. National Health Service Corps loan repayments.
“Sec. 138. Cross references to other Acts.”.

13 (4) EFFECTIVE DATE.—The amendments made
14 by this subsection shall apply to payments made
15 under section 338B(g) of the Public Health Service
16 Act after the date of the enactment of this Act.

17 (b) STUDY REGARDING DESIGNATION AS HEALTH
18 PROFESSIONAL SHORTAGE AREA; ALLOCATION OF CORPS
19 MEMBERS AMONG SHORTAGE AREAS.—

20 (1) IN GENERAL.—The Secretary of Health and
21 Human Services (in this subsection referred to as
22 the “Secretary”) shall conduct a study for the pur-
23 pose of determining the following:

1 (A) With respect to the designation of
2 health professional shortage areas under sub-
3 part II of part D of title III of the Public
4 Health Service Act—

5 (i) whether the statutory and adminis-
6 trative criteria for the designation of such
7 areas should be modified to ensure that all
8 areas with significant shortages of health
9 professionals receive such a designation;
10 and

11 (ii) if so, the recommendations of the
12 Secretary for modifications in the criteria.

13 (B) With respect to the assignment of
14 members of the National Health Service Corps
15 under such subpart—

16 (i) whether the statutory and adminis-
17 trative criteria for the assignment of Corps
18 members should be modified in order to
19 ensure that the members are equitably al-
20 located among health professional shortage
21 areas; and

22 (ii) if so, the recommendations of the
23 Secretary for modifications in the criteria.

24 (2) REPORT.—Not later than May 1, 1996, the
25 Secretary shall complete the study required in para-

graph (1) and submit to the Congress a report describing the findings made in the study.

(c) OTHER PROVISIONS REGARDING NATIONAL HEALTH SERVICE CORPS.—

(1) PRIORITY IN ASSIGNMENT OF CORPS MEMBERS; COMMUNITY RURAL HEALTH NETWORKS.—

Section 333A(a)(1)(B) of the Public Health Service Act (42 U.S.C. 254f–1(a)(1)(B)) is amended—

(A) in clause (iii), by striking “and” after the semicolon at the end;

(B) in clause (iv), by adding “and” after the semicolon at the end; and

(B) by adding at the end the following clause:

“(v) is a participant in a community rural health network, as defined in section 15501 of the Medicare Preservation Act of 1995.”.

(2) ALLOCATION FOR PARTICIPATION OF NURSES IN SCHOLARSHIP PROGRAM.—Section 338H(b)(2) of the Public Health Service Act (42 U.S.C. 254q(b)(2)) is amended by adding at the end the following subparagraph:

“(C) Of the amounts appropriated under paragraph (1) for fiscal year 1996 and subse-

1 quent fiscal years, the Secretary shall reserve
2 such amounts as may be necessary to ensure
3 that, of the aggregate number of individuals
4 who are participants in the Scholarship Pro-
5 gram, the total number who are being educated
6 as nurses or are serving as nurses, respectively,
7 is increased to 20 percent.”.

8 **SEC. 15504. CREATION OF HOSPITAL-AFFILIATED PRIMARY**
9 **CARE CENTERS.**

10 Section 330 of the Public Health Service Act (42
11 U.S.C. 254c) is amended by adding at the end the follow-
12 ing subsection:

13 “(l) Of the amounts appropriated under subsection
14 (g)(1)(A) for a fiscal year, the Secretary shall reserve not
15 less than 10 percent, and not more than 20 percent, for
16 the establishment and operation of hospital-affiliated pri-
17 mary care centers, as defined in section 15504 of the Med-
18 icare Preservation Act of 1995.”.

19 **SEC. 15505. ESTABLISHMENT OF RURAL EMERGENCY AC-**
20 **CESS CARE HOSPITALS.**

21 (a) ESTABLISHMENT.—

22 (1) IN GENERAL.—Section 1861 (42 U.S.C.
23 1395x) is amended by adding at the end the follow-
24 ing new subsection:

1 “Rural Emergency Access Care Hospital; Rural
2 Emergency Access Care Hospital Services

3 “(oo)(1) The term ‘rural emergency access care hos-
4 pital’ means, for a fiscal year, a facility with respect to
5 which the Secretary finds the following:

6 “(A) The facility is located in a rural area (as
7 defined in section 1886(d)(2)(D)).

8 “(B) The facility was a hospital under this title
9 at any time during the 5-year period that ends on
10 the date of the enactment of this subsection.

11 “(C) The facility is in danger of closing due to
12 low inpatient utilization rates and operating losses,
13 and the closure of the facility would limit the access
14 to emergency services of individuals residing in the
15 facility’s service area.

16 “(D) The facility has entered into (or plans to
17 enter into) an agreement with a hospital with a par-
18 ticipation agreement in effect under section 1866(a),
19 and under such agreement the hospital shall accept
20 patients transferred to the hospital from the facility
21 and receive data from and transmit data to the
22 facility.

23 “(E) There is a practitioner who is qualified to
24 provide advanced cardiac life support services (as de-

1 terminated by the State in which the facility is lo-
2 cated) on-site at the facility on a 24-hour basis.

3 “(F) A physician is available on-call to provide
4 emergency medical services on a 24-hour basis.

5 “(G) The facility meets such staffing require-
6 ments as would apply under section 1861(e) to a
7 hospital located in a rural area, except that—

8 “(i) the facility need not meet hospital
9 standards relating to the number of hours dur-
10 ing a day, or days during a week, in which the
11 facility must be open, except insofar as the fa-
12 cility is required to provide emergency care on
13 a 24-hour basis under subparagraphs (E) and
14 (F); and

15 “(ii) the facility may provide any services
16 otherwise required to be provided by a full-time,
17 on-site dietitian, pharmacist, laboratory techni-
18 cian, medical technologist, or radiological tech-
19 nologist on a part-time, off-site basis.

20 “(H) The facility meets the requirements appli-
21 cable to clinics and facilities under subparagraphs
22 (C) through (J) of paragraph (2) of section
23 1861(aa) and of clauses (ii) and (iv) of the second
24 sentence of such paragraph (or, in the case of the
25 requirements of subparagraph (E), (F), or (J) of

such paragraph, would meet the requirements if any reference in such subparagraph to a ‘nurse practitioner’ or to ‘nurse practitioners’ were deemed to be a reference to a ‘nurse practitioner or nurse’ or to ‘nurse practitioners or nurses’; except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a ‘physician’ is a reference to a physician as defined in section 1861(r)(1).

“(2) The term ‘rural emergency access care hospital services’ means the following services provided by a rural emergency access care hospital and furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather):

“(A) An appropriate medical screening examination (as described in section 1867(a)).

“(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).”.

(2) **REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.**—Section 1867(e)(5) (42 U.S.C.

1 1395dd(e)(5)) is amended by striking
2 “1861(mm)(1))” and inserting “1861(mm)(1)) and
3 a rural emergency access care hospital (as defined in
4 section 1861(oo)(1))”.

5 (b) COVERAGE AND PAYMENT UNDER PART B.—

6 (1) COVERAGE UNDER PART B.—Section
7 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

8 (A) by striking “and” at the end of sub-
9 paragraph (I);

10 (B) by striking the period at the end of
11 subparagraph (J) and inserting “; and”; and

12 (C) by adding at the end the following new
13 subparagraph:

14 “(K) rural emergency access care hospital
15 services (as defined in section 1861(oo)(2)).”.

16 (2) PAYMENT BASED ON PAYMENT FOR OUT-
17 PATIENT RURAL PRIMARY CARE HOSPITAL SERV-
18 ICES.—

19 (A) IN GENERAL.—Section 1833(a)(6) (42
20 U.S.C. 1395l(a)(6)) is amended by striking
21 “services,” and inserting “services and rural
22 emergency access care hospital services,”.

23 (B) PAYMENT METHODOLOGY DE-
24 SCRIBED.—Section 1834(g) (42 U.S.C.
25 1395m(g)) is amended—

(i) in the heading, by striking “SERVICES” and inserting “SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES”; and

(ii) by adding at the end the following new sentence: “The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to fiscal years beginning on or after October 1, 1995.

SEC. 15506. MEDICAL EDUCATION.

(a) **STATE AND CONSORTIUM DEMONSTRATION PROJECTS.**—

(1) **IN GENERAL.**—

(A) **PARTICIPATION OF STATES AND CONSORTIA.**—The Secretary shall establish and conduct a demonstration project to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice under which

1 the Secretary shall make payments in accord-
2 ance with paragraph (4)—

3 (i) to not more than 10 States for the
4 purpose of testing and evaluating mecha-
5 nisms to meet the goals described in sub-
6 section (b); and

7 (ii) to not more than 10 health care
8 training consortia for the purpose of test-
9 ing and evaluating mechanisms to meet
10 such goals.

11 (B) EXCLUSION OF CONSORTIA IN PAR-
12 TICIPATING STATES.—A consortia may not re-
13 ceive payments under the demonstration project
14 under subparagraph (A)(ii) if any of its mem-
15 bers is located in a State receiving payments
16 under the project under subparagraph (A)(i).

17 (2) APPLICATIONS.—

18 (A) IN GENERAL.—Each State and consor-
19 tium desiring to conduct a demonstration
20 project under this subsection shall prepare and
21 submit to the Secretary an application, at such
22 time, in such manner, and containing such in-
23 formation as the Secretary may require to as-
24 sure that the State or consortium will meet the
25 goals described in subsection (b). In the case

of an application of a State, the application shall include—

(i) information demonstrating that the State has consulted with interested parties with respect to the project, including State medical associations, State hospital associations, and medical schools located in the State;

(ii) an assurance that no hospital conducting an approved medical residency training program in the State will lose more than 10 percent of such hospital's approved medical residency positions in any year as a result of the project; and

(iii) an explanation of a plan for evaluating the impact of the project in the State.

(B) APPROVAL OF APPLICATIONS.—A State or consortium that submits an application under subparagraph (A) may begin a demonstration project under this subsection—

(i) upon approval of such application by the Secretary; or

(ii) at the end of the 60-day period beginning on the date such application is

1 submitted, unless the Secretary denies the
2 application during such period.

3 (C) NOTICE AND COMMENT.—A State or
4 consortium shall issue a public notice on the
5 date it submits an application under subpara-
6 graph (A) which contains a general description
7 of the proposed demonstration project. Any in-
8 terested party may comment on the proposed
9 demonstration project to the State or consor-
10 tium or the Secretary during the 30-day period
11 beginning on the date the public notice is is-
12 sued.

13 (3) SPECIFIC REQUIREMENTS FOR PARTICI-
14 PANTS.—

15 (A) REQUIREMENTS FOR STATES.—Each
16 State participating in the demonstration project
17 under this section shall use the payments pro-
18 vided under paragraph (4) to test and evaluate
19 either of the following mechanisms to increase
20 the number and percentage of medical students
21 entering primary care practice relative to those
22 entering nonprimary care practice:

23 (i) USE OF ALTERNATIVE WEIGHTING
24 FACTORS.—

(I) IN GENERAL.—The State may make payments to hospitals in the State for direct graduate medical education costs in amounts determined under the methodology provided under section 1886(h) of the Social Security Act, except that the State shall apply weighting factors that are different than the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

(II) USE OF PAYMENTS FOR PRIMARY CARE RESIDENTS.—In applying different weighting factors under subclause (I), the State shall ensure that the amount of payment made to hospitals for costs attributable to primary care residents shall be greater than the amount that would have been paid to hospitals for costs attributable to such residents if the State had applied the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

1 (ii) PAYMENTS FOR MEDICAL EDU-
 2 CATION THROUGH CONSORTIUM.—The
 3 State may make payments for graduate
 4 medical education costs through payments
 5 to a health care training consortium (or
 6 through any entity identified by such a
 7 consortium as appropriate for receiving
 8 payments on behalf of the consortium) that
 9 is established in the State but that is not
 10 otherwise participating in the demonstra-
 11 tion project.

12 (B) REQUIREMENTS FOR CONSORTIUM.—

13 (i) IN GENERAL.—In the case of a
 14 consortium participating in the demonstra-
 15 tion project under this section, the Sec-
 16 retary shall make payments for graduate
 17 medical education costs through a health
 18 care training consortium whose members
 19 provide medical residency training (or
 20 through any entity identified by such a
 21 consortium as appropriate for receiving
 22 payments on behalf of the consortium).

23 (ii) USE OF PAYMENTS.—

24 (I) IN GENERAL.—Each consor-
 25 tium receiving payments under clause

(i) shall use such funds to conduct activities which test and evaluate mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice, and may use such funds for the operation of the consortium.

(II) PAYMENTS TO PARTICIPATING PROGRAMS.—The consortium shall ensure that the majority of the payments received under clause (i) are directed to consortium members for primary care residency programs, and shall designate for each resident assigned to the consortium a hospital operating an approved medical residency training program for purposes of enabling the Secretary to calculate the consortium's payment amount under the project. Such hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, nonambulatory training experience.

1 (4) ALLOCATION OF PORTION OF MEDICARE
2 GME PAYMENTS FOR ACTIVITIES UNDER PROJECT.—
3 Notwithstanding any provision of title XVIII of the
4 Social Security Act, the following rules apply with
5 respect to each State and each health care training
6 consortium participating in the demonstration
7 project established under this subsection during a
8 year:

9 (A) In the case of a State—

10 (i) the Secretary shall reduce the
11 amount of each payment made to hospitals
12 in the State during the year for direct
13 graduate medical education costs under
14 section 1886(h) of the Social Security Act
15 by 3 percent; and

16 (ii) the Secretary shall pay the State
17 an amount equal to the Secretary's esti-
18 mate of the sum of the reductions made
19 during the year under clause (i) (as ad-
20 justed by the Secretary in subsequent
21 years for over- or under-estimations in the
22 amount estimated under this subparagraph
23 in previous years).

24 (B) In the case of a consortium—

(i) the Secretary shall reduce the amount of each payment made to hospitals who are members of the consortium during the year for direct graduate medical education costs under section 1886(h) of the Social Security Act by 3 percent; and

(ii) the Secretary shall pay the consortium an amount equal to the Secretary's estimate of the sum of the reductions made during the year under clause (i) (as adjusted by the Secretary in subsequent years for over- or under-estimations in the amount estimated under this subparagraph in previous years).

(5) ADDITIONAL GRANT FOR PLANNING AND EVALUATION.—

(A) IN GENERAL.—The Secretary may award grants to States and consortia participating in the demonstration project under this subsection for the purpose of planning and evaluating such projects. A State or consortia may conduct such planning and evaluation activities or contract with a private entity to conduct such activities. Each State and consortia desiring to receive a grant under this subparagraph

1 shall prepare and submit to the Secretary an
2 application, at such time, in such manner, and
3 containing such information as the Secretary
4 may require.

5 (B) AUTHORIZATION OF APPROPRIA-
6 TIONS.—There are authorized to be appro-
7 priated for grants under this subparagraph
8 \$250,000 for fiscal year 1996, and \$100,000
9 for each of the fiscal years 1997 through 2001.

10 (6) DURATION.—A demonstration project under
11 this subsection shall be conducted for a period not
12 to exceed 5 years. The Secretary may terminate a
13 project if the Secretary determines that the State or
14 consortium conducting the project is not in substan-
15 tial compliance with the terms of the application ap-
16 proved by the Secretary.

17 (7) EVALUATIONS AND REPORTS.—

18 (A) EVALUATIONS.—Each State or consor-
19 tium participating in the demonstration project
20 shall submit to the Secretary a final evaluation
21 within 360 days of the termination of the State
22 or consortium's participation and such interim
23 evaluations as the Secretary may require.

24 (B) REPORTS TO CONGRESS.—Not later
25 than 360 days after the first demonstration

project under this section begins, and annually thereafter for each year in which such a project is conducted, the Secretary shall submit a report to Congress which evaluates the effectiveness of the State and consortium activities conducted under such projects and includes any legislative recommendations determined appropriate by the Secretary.

(8) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project under this section shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

(b) GOALS FOR PROJECTS.—The goals referred to in this subsection for a State or consortium participating in the demonstration project under this section are as follows:

(1) The training of an equal number of physician and nonphysician primary care providers.

(2) The recruiting of residents for graduate medical education training programs who received a portion of undergraduate training in a rural area.

(3) The allocation of not less than 50 percent of the training spent in a graduate medical residency

1 training program at sites at which acute care inpa-
2 tient hospital services are not furnished.

3 (4) The rotation of residents in approved medi-
4 cal residency training programs among practices
5 that serve residents of rural areas.

6 (5) The development of a plan under which,
7 after a 5-year transition period, not less than 50
8 percent of the residents who begin an initial resi-
9 dency period in an approved medical residency train-
10 ing program shall be primary care residents.

11 (c) DEFINITIONS.—In this section:

12 (1) APPROVED MEDICAL RESIDENCY TRAINING
13 PROGRAM.—The term “approved medical residency
14 training program” has the meaning given such term
15 in section 1886(h)(5)(A) of the Social Security Act.

16 (2) HEALTH CARE TRAINING CONSORTIUM.—
17 The term “health care training consortium” means
18 a State, regional, or local entity consisting of at
19 least one of each of the following:

20 (A) A hospital operating an approved med-
21 ical residency training program at which resi-
22 dents receive training at ambulatory training
23 sites located in rural areas.

24 (B) A school of medicine or osteopathic
25 medicine.

(C) A school of allied health or a program for the training of physician assistants (as such terms are defined in section 799 of the Public Health Service Act).

(D) A school of nursing (as defined in section 853 of the Public Health Service Act).

(3) PRIMARY CARE.—The term “primary care” means family practice, general internal medicine, general pediatrics, and obstetrics and gynecology.

(4) RESIDENT.—The term “resident” has the meaning given such term in section 1886(h)(5)(H) of the Social Security Act.

(5) RURAL AREA.—The term “rural area” has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

SEC. 15507. TELEMEDICINE PAYMENT METHODOLOGY.

The Secretary of Health and Human Services shall establish a methodology for making payments under part B of the medicare program for telemedicine services furnished on an emergency basis to individuals residing in an area designated as a health professional shortage area (under section 332(a) of the Public Health Service Act).

1 **SEC. 15508. DEMONSTRATION PROJECT TO INCREASE**
 2 **CHOICE IN RURAL AREAS.**

3 The Secretary of Health and Human Services (acting
 4 through the Administrator of the Health Care Financing
 5 Administration) shall conduct a demonstration project to
 6 assess the advantages and disadvantages of requiring
 7 Medicare Choice organizations under part C of title XVIII
 8 of the Social Security Act (as added by section 15002(a))
 9 to market Medicare Choice products in certain under-
 10 served areas which are near the standard service area for
 11 such products.

12 **PART 2—MEDICARE SUBVENTION**

13 **SEC. 15511. MEDICARE PROGRAM PAYMENTS FOR HEALTH**
 14 **CARE SERVICES PROVIDED IN THE MILITARY**
 15 **HEALTH SERVICES SYSTEM.**

16 (a) **PAYMENTS UNDER MEDICARE RISK CONTRACTS**
 17 **PROGRAM.—**

18 (1) **CURRENT PROGRAM.—**Section 1876 (42
 19 U.S.C. 1395mm) is amended by adding at the end
 20 the following new subsection:

21 “(k) Notwithstanding any other provision of this sec-
 22 tion, a managed health care plan established by the Sec-
 23 retary of Defense under chapter 55 of title 10, United
 24 States Code, shall be considered an eligible organization
 25 under this section, and the Secretary shall make payments
 26 to such a managed health care plan during a year on be-

1 half of any individuals entitled to benefits under this title
2 who are enrolled in such a managed health care plan dur-
3 ing the year. Such payments shall be made in the same
4 amounts and under similar terms and conditions under
5 which the Secretary makes payments to other eligible
6 organizations with risk sharing contracts under this
7 section.”.

8 (2) MEDICARE CHOICE PROGRAM.—Section
9 1855, as inserted by section 15002(a), by adding at
10 the end the following new subsection:

11 “(h) PAYMENTS TO MILITARY PROGRAM.—Notwith-
12 standing any other provision of this section, a managed
13 health care plan established by the Secretary of Defense
14 under chapter 55 of title 10, United States Code, shall
15 be considered a Medicare Choice organization under this
16 part, and the Secretary shall make payments to such a
17 managed health care plan during a year on behalf of any
18 individuals entitled to benefits under this title who are en-
19 rolled in such a managed health care plan during the year.
20 Such payments shall be made in the same amounts and
21 under similar terms and conditions under which the Sec-
22 retary makes payments to other Medicare Choice organi-
23 zations with contracts in effect under this part.”.

24 (b) TEMPORARY PROVISION FOR WAIVER OF PART
25 B PREMIUM PENALTY.—Section 1839 (42 U.S.C. 1395r)

1 is amended by adding at the end the following new sub-
2 section:

3 “(h) The premium increase required by subsection
4 (b) shall not apply with respect to a person who is enrolled
5 with a managed care plan that is established by the Sec-
6 retary of Defense under chapter 55 of title 10, United
7 States Code, and is recognized as an eligible organization
8 pursuant to section 1855(h) or section 1876(k), if such
9 person first enrolled in such plan prior to January 1,
10 1998.”.

11 (c) PAYMENTS UNDER PART A OF MEDICARE.—Sec-
12 tion 1814(c) (42 U.S.C. 1395f(c)) is amended—

13 (1) by redesignating the current matter as
14 paragraph (1); and

15 (2) by adding at the end the following new
16 paragraph:

17 “(2) Paragraph (1) shall not apply to services
18 provided by facilities of the uniformed services pur-
19 suant to chapter 55 of title 10, United States Code,
20 and subject to the provisions of section 1095 of such
21 title. With respect to such services, payments under
22 this title shall be made without regard to whether
23 the beneficiary under this title has paid the deduct-
24 ible and copayments amounts generally required by
25 this title.”.

1 (d) PAYMENTS UNDER PART B OF MEDICARE.—Sec-
2 tion 1835(d) (42 U.S.C. 1395n(d)) is amended—

3 (1) by redesignating the current matter as
4 paragraph (1); and

5 (2) by adding at the end the following new
6 paragraph:

7 “(2) Paragraph (1) shall not apply to services pro-
8 vided by facilities of the uniformed services pursuant to
9 chapter 55 of title 10, United States Code, and subject
10 to the provisions of section 1095 of such title. With respect
11 to such services, payments under this title shall be made
12 without regard to whether the beneficiary under this title
13 has paid the deductible and copayments amounts generally
14 required by this title.”.

15 (e) CONFORMING AMENDMENTS TO THE THIRD
16 PARTY COLLECTION PROGRAM FOR MILITARY MEDICAL
17 FACILITIES.—(1) Section 1095(d) of title 10, United
18 States Code, is amended—

19 (A) by striking “XVIII or”; and

20 (B) by striking “1395” and inserting “1396”.

21 (2) Section 1095(h)(2) of such title is amended by
22 inserting after “includes” the following: “plans adminis-
23 tered under title XVIII of the Social Security Act (42
24 U.S.C. 1395 et seq.),”.

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect at the end of the 30-day period beginning on the date of the enactment of this Act.

Subtitle G—Other Provisions

SEC. 15601. EXTENSION AND EXPANSION OF EXISTING SECONDARY PAYER REQUIREMENTS.

(a) DATA MATCH.—

- (1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).
- (2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

- (1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

- (A) in clause (i), by striking “clause (iv)” and inserting “clause (iii)”,
- (B) by striking clause (iii), and
- (C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs

- (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by

striking “1862(b)(1)(B)(iv)” each place it appears
and inserting “1862(b)(1)(B)(iii)”.

(c) EXPANSION OF PERIOD OF APPLICATION TO INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking “12-month” each place it appears and inserting “24-month”, and

(2) by striking the second sentence.

SEC. 15602. CLARIFICATION OF MEDICARE COVERAGE OF ITEMS AND SERVICES ASSOCIATED WITH CERTAIN MEDICAL DEVICES APPROVED FOR INVESTIGATIONAL USE.

(a) COVERAGE.—Nothing in title XVIII of the Social Security Act may be construed to prohibit coverage under part A or part B of the medicare program of items and services associated with the use of a medical device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) for which payment may be made under the program solely on the grounds that the device is not an approved device, if—

(1) the device is an investigational device; and

(2) the device is used instead of either an approved device or a covered procedure.

1 (b) CLARIFICATION OF PAYMENT AMOUNT.—Not-
 2 withstanding any other provision of title XVIII of the So-
 3 cial Security Act, the amount of payment made under the
 4 medicare program for any item or service associated with
 5 the use of an investigational device in the furnishing of
 6 inpatient or outpatient hospital services (including out-
 7 patient diagnostic imaging services) for which payment
 8 may be made under the program may not exceed the
 9 amount of the payment which would have been made
 10 under the program for the item or service if the item or
 11 service were associated with the use of an approved device
 12 or a covered procedure.

13 (c) DEFINITIONS.—In this section—

14 (1) the term “approved device” means a medi-
 15 cal device (or devices) which has been approved for
 16 marketing under pre-market approval under the
 17 Federal Food, Drug, and Cosmetic Act or cleared
 18 for marketing under a 510(k) notice under such Act;
 19 and

20 (2) the term “investigational device” means—

21 (A) a medical device or devices (other than
 22 a device described in paragraph (1)) approved
 23 for investigational use under section 520(g) of
 24 the Federal Food, Drug, and Cosmetic Act, or

(B) a product authorized for use under section 505(i) of the Federal Food, Drug, and Cosmetic Act which includes the use of a medical device (or devices) or an investigational combination product under section 503(g) of such Act which includes a device (or devices) authorized for use under section 505(i) of such Act.

SEC. 15603. ADDITIONAL EXCLUSION FROM COVERAGE.

(a) IN GENERAL.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking “or” at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting “; or”, and

(3) by inserting after paragraph (15) the following new paragraph:

“(16) where such expenses are for items or services, or to assist in the purchase, in whole or in part, of health benefit coverage that includes items or services, for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payment for items and serv-

ices furnished on or after the date of the enactment of this Act.

Subtitle H—Monitoring Achievement of Medicare Reform Goals

SEC. 15701. ESTABLISHMENT OF BUDGETARY AND PROGRAM GOALS.

(a) IN GENERAL.—The Secretary shall establish program budgetary and program goals for the medicare program consistent with this section.

(b) BUDGETARY GOALS.—The budgetary goal is to restrict total outlays under the medicare program as follows:

(1) For fiscal year 1996, \$_____.

(2) For fiscal year 1997, \$_____.

(3) For fiscal year 1998, \$_____.

(4) For fiscal year 1999, \$_____.

(5) For fiscal year 2000, \$_____.

(6) For fiscal year 2001, \$_____.

(7) For fiscal year 2002, \$_____.

(c) PROGRAM GOALS.—The program goals shall be consistent with the following:

(1) There should be an equitable distribution of funds between per beneficiary spending on payments to Medicare Choice organizations under part C of the medicare program and on payments to providers

on a fee-for-service basis under parts A and B of the program.

(2) Payments to Medicare Choice organizations should be established in a manner that promotes the availability of Medicare Choice products in all regions of the country and that permits such organizations to offer adequate coverage.

SEC. 15702. MEDICARE REFORM COMMISSION.

(a) ESTABLISHMENT.—There is established a commission to be known as the Medicare Reform Commission (in this section referred to as the “Commission”).

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall examine how the medicare program has met the budgetary and program goals established under section 15701.

(2) PERIODIC REPORTS.—

(A) IN GENERAL.—The Commission shall issue a report on April 1, 1998, and on March 1 of every third subsequent year, on the status of the medicare program in relation to the budgetary and program goals specified in section 15601.

(B) CONTENTS.—Each report shall include the following information about the medicare

1 program in the most recent fiscal year and
2 projects for the succeeding 3 fiscal years:

3 (i) The actuarial value of the tradi-
4 tional medicare benefit package.

5 (ii) The projected rate of growth of
6 outlays under the traditional medicare pro-
7 gram.

8 (iii) The ability of Medicare Choice or-
9 ganizations to offer an adequate benefit
10 package under part C of the medicare pro-
11 gram.

12 (iv) The extent of Medicare Choice
13 products made available to medicare bene-
14 ficiaries in the different regions of the
15 country.

16 (3) RECOMMENDATIONS.—

17 (A) IN GENERAL.—If a report under para-
18 graph (2) finds that any of the following prob-
19 lems exists, the Commission shall include rec-
20 ommendations to respond to the problem:

21 (i) The actuarial value of the tradi-
22 tional medicare benefit package exceeds
23 the payment rate under the Medicare
24 Choice program.

(ii) The rate of growth of the traditional medicare program under parts A and B is projected to result in medicare outlays exceeding the outlay targets specified in section 15701.

(iii) The payments under the Medicare Choice program are not sufficient to allow contractors to provide an adequate benefit package.

(iv) The selection of Medicare Choice products are limited or not available in parts of the country.

(B) TYPES OF RECOMMENDATIONS.—The recommendations provided under subparagraph (A) may include—

(i) in response to the problem described in subparagraph (A)(ii), reduction in payments to providers under parts A and B or an increase in cost sharing by beneficiaries; and

(ii) in response to the problems described in subparagraphs (A)(iii) and (A)(iv), an adjustment to payment rates to Medicare Choice organizations.

1 Such recommendations may not include any
2 change that is inconsistent with attaining the
3 outlay targets specified under section 15701.

4 (4) PRESIDENTIAL RESPONSE.—If the Commis-
5 sion reports under this subsection that the goals es-
6 tablished in section 15701 are not met (or projects
7 that such goals will not be met during a 3-year pe-
8 riod), the President shall submit to Congress, within
9 90 days after the date of submission of the report,
10 specific legislative recommendations to correct the
11 problem. Such recommendations may include those
12 described in paragraph (3)(B) and may not include
13 any change that is inconsistent with attaining the
14 outlay targets specified under section 15701.

15 (5) CONGRESSIONAL CONSIDERATION.—

16 (A) IN GENERAL.—The President's rec-
17 ommendations submitted under paragraph (4)
18 shall not apply unless a joint resolution (de-
19 scribed in subparagraph (B)) approving such
20 recommendations is enacted, in accordance with
21 the provisions of subparagraph (C), before the
22 end of the 60-day period beginning on the date
23 on which a report containing such recommenda-
24 tions is submitted by the President under para-
25 graph (4). For purposes of applying the preced-

ing sentence and subparagraphs (B) and (C),
the days on which either House of Congress is
not in session because of an adjournment of
more than three days to a day certain shall be
excluded in the computation of a period.

(B) JOINT RESOLUTION OF APPROVAL.—A
joint resolution described in this subparagraph
means only a joint resolution which is intro-
duced within the 10-day period beginning on
the date on which the report described in sub-
paragraph (A) is submitted and—

(i) which does not have a preamble;

(ii) the matter after the resolving
clause of which is as follows: “That Con-
gress approves the recommendations of the
President under section 15702(b)(4) of the
Medicare Preservation Act, as submitted
by the President on _____.”,
the blank space being filled in with the ap-
propriate date; and

(iii) the title of which is as follows:
“Joint resolution approving Presidential
recommendations submitted under section
15702(b)(4) of the Medicare Preservation
Act, as submitted by the President on

1 _____.”, the blank space being
2 filled in with the appropriate date.

3 (C) PROCEDURES FOR CONSIDERATION OF
4 RESOLUTION OF APPROVAL.—Subject to sub-
5 paragraph (D), the provisions of section 2908
6 (other than subsection (a)) of the Defense Base
7 Closure and Realignment Act of 1990 shall
8 apply to the consideration of a joint resolution
9 described in subparagraph (B) in the same
10 manner as such provisions apply to a joint reso-
11 lution described in section 2908(a) of such Act.

12 (D) SPECIAL RULES.—For purposes of ap-
13 plying subparagraph (C) with respect to such
14 provisions—

15 (i) any reference to the Committee on
16 Armed Services of the House of Represent-
17 atives shall be deemed a reference to the
18 Committee on Ways and Means and any
19 reference to the Committee on Armed
20 Services of the Senate shall be deemed a
21 reference to the Committee on Finance of
22 the Senate; and

23 (ii) any reference to the date on which
24 the President transmits a report shall be
25 deemed a reference to the date on which

the President submits the recommendations under paragraph (4).

(c) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall be composed of 5 members appointed by the President, of which 4 of whom are appointed from a list (of at least 5 nominees) submitted by each of the following:

(A) The Speaker of the House of Representatives.

(B) The Minority Leader of the House of Representatives.

(C) The Majority Leader of the Senate.

(D) The Minority Leader of the Senate.

(2) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a Chairman and Vice Chairman from among its members.

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(4) QUORUM.—A quorum shall consist of 3 members of the Commission, except that 2 members may conduct a hearing under subsection (e).

1 (5) MEETINGS.—The Commission shall meet at
2 the call of its Chairman or a majority of its mem-
3 bers.

4 (6) COMPENSATION AND REIMBURSEMENT OF
5 EXPENSES.—Members of the Commission are not
6 entitled to receive compensation for service on the
7 Commission. Members may be reimbursed for travel,
8 subsistence, and other necessary expenses incurred
9 in carrying out the duties of the Commission.

10 (d) STAFF AND CONSULTANTS.—

11 (1) STAFF.—The Commission may appoint and
12 determine the compensation of such staff as may be
13 necessary to carry out the duties of the Commission.
14 Such appointments and compensation may be made
15 without regard to the provisions of title 5, United
16 States Code, that govern appointments in the com-
17 petitive services, and the provisions of chapter 51
18 and subchapter III of chapter 53 of such title that
19 relate to classifications and the General Schedule
20 pay rates.

21 (2) CONSULTANTS.—The Commission may pro-
22 cure such temporary and intermittent services of
23 consultants under section 3109(b) of title 5, United
24 States Code, as the Commission determines to be
25 necessary to carry out the duties of the Commission.

1 (e) POWERS.—

2 (1) HEARINGS AND OTHER ACTIVITIES.—For
3 the purpose of carrying out its duties, the Commis-
4 sion may hold such hearings and undertake such
5 other activities as the Commission determines to be
6 necessary to carry out its duties.

7 (2) STUDIES BY GAO.—Upon the request of the
8 Commission, the Comptroller General shall conduct
9 such studies or investigations as the Commission de-
10 termines to be necessary to carry out its duties.

11 (3) COST ESTIMATES BY CONGRESSIONAL
12 BUDGET OFFICE.—

13 (A) Upon the request of the Commission,
14 the Director of the Congressional Budget Office
15 shall provide to the Commission such cost esti-
16 mates as the Commission determines to be nec-
17 essary to carry out its duties.

18 (B) The Commission shall reimburse the
19 Director of the Congressional Budget Office for
20 expenses relating to the employment in the of-
21 fice of the Director of such additional staff as
22 may be necessary for the Director to comply
23 with requests by the Commission under sub-
24 paragraph (A).

1 (4) DETAIL OF FEDERAL EMPLOYEES.—Upon
2 the request of the Commission, the head of any Fed-
3 eral agency is authorized to detail, without reim-
4 bursement, any of the personnel of such agency to
5 the Commission to assist the Commission in carry-
6 ing out its duties. Any such detail shall not interrupt
7 or otherwise affect the civil service status or privi-
8 leges of the Federal employee.

9 (5) TECHNICAL ASSISTANCE.—Upon the re-
10 quest of the Commission, the head of a Federal
11 agency shall provide such technical assistance to the
12 Commission as the Commission determines to be
13 necessary to carry out its duties.

14 (6) USE OF MAILS.—The Commission may use
15 the United States mails in the same manner and
16 under the same conditions as Federal agencies and
17 shall, for purposes of the frank, be considered a
18 commission of Congress as described in section 3215
19 of title 39, United States Code.

20 (7) OBTAINING INFORMATION.—The Commis-
21 sion may secure directly from any Federal agency
22 information necessary to enable it to carry out its
23 duties, if the information may be disclosed under
24 section 552 of title 5, United States Code. Upon re-
25 quest of the Chairman of the Commission, the head

of such agency shall furnish such information to the Commission. In particular, the Administrator of the Health Care Financing Administration and the Director of the Office of Management and Budget shall provide the Commission with access to data for the conduct of its work.

(8) ADMINISTRATIVE SUPPORT SERVICES.—

Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) ACCEPTANCE OF DONATIONS.—The Com-

mission may accept, use, and dispose of gifts or donations of services or property.

(10) PRINTING.—For purposes of costs relating

to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(f) AUTHORIZATION OF APPROPRIATIONS.—There

are authorized to be appropriated such sums as may be necessary to carry out this section. Amounts appropriated to carry out this section shall remain available until expended.

1 Subtitle I—Lock-Box Provisions for
2 Medicare Part B Savings from
3 Growth Reductions

4 SEC. 15801. ESTABLISHMENT OF MEDICARE GROWTH RE-
5 Duction Trust Fund for Part B Savings.

6 Part B of title XVIII is amended by inserting after
7 section 1841 the following new section:

8 “MEDICARE GROWTH REDUCTION TRUST FUND

9 “SEC. 1841A. (a)(1) There is hereby created on the
10 books of the Treasury of the United States a trust fund
11 to be known as the ‘Federal Medicare Growth Reduction
12 Trust Fund’ (in this section referred to as the ‘Trust
13 Fund’). The Trust Fund shall consist of such gifts and
14 bequests as may be made as provided in section 201(i)(1)
15 and amounts appropriated under paragraph (2).

16 “(2) There are hereby appropriated to the Trust
17 Fund amounts equivalent to 100 percent of the Sec-
18 retary’s estimate of the reductions in expenditures under
19 this part that are attributable to the Medicare Preserva-
20 tion Act of 1995. The amounts appropriated by the pre-
21 ceding sentence shall be transferred from time to time (not
22 less frequently than monthly) from the general fund in the
23 Treasury to the Trust Fund.

24 “(3)(A) Subject to subparagraph (B), with respect to
25 monies transferred to the Trust Fund, no transfers, au-

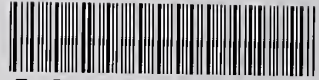
1 thorizations of appropriations, or appropriations are per-
2 mitted.

3 “(B) Beginning with fiscal year 2003, the Secretary
4 may expend funds in the Trust Fund to carry out this
5 title, but only to the extent provided by Congress in ad-
6 vance through a specific amendment to this section.

7 “(b) The provisions of subsections (b) through (e) of
8 section 1841 shall apply to the Trust Fund in the same
9 manner as they apply to the Federal Supplementary Medi-
10 cal Insurance Trust Fund, except that the Board of Trust-
11 ees and Managing Trustee of the Trust Fund shall be
12 composed of the members of the Board of Trustees and
13 the Managing Trustee, respectively, of the Federal Supple-
14 mentary Medical Insurance Trust Fund.”.

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